

**Evaluation of Impacts of Medicare Modernization Act Changes on
Dual Eligible Beneficiaries in Demonstration and Other Managed
Care and Fee-For-Service Settings**

**Final Report on Task 5:
Examination of the Changing Context for Dual Demonstration Contractors**

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Executive Summary

This study was conducted under a contract from the Centers for Medicare and Medicaid (CMS) that had two aims: (1) describe best practices from 11 demonstration health plans operating in three states and offering comprehensive managed care to dual-eligible beneficiaries (eligible for both Medicare and Medicaid), and (2) assess the impact of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the MMA) on these plans and their members. A separate report dealt with the first aim (Bishop, Leutz et al. 2006), and this report addresses the second, with particular focus on MMA impacts in three areas: finances/the bidding process, marketing, and prescription drugs.

New MMA provisions

The MMA transformed and expanded Medicare + Choice --now called Medicare Advantage (MA) -- including five new provisions that are particularly relevant to health plans serving dual-eligible beneficiaries:

1. A Special Needs Plan (SNP) provision was created to allow plans to serve any of three categories of beneficiaries: those residing in institutions, those eligible for Medicaid, and those with severe or disabling conditions who would benefit from enrollment in a SNP.
2. A new Medicare Part D prescription drug benefit covers most medications previously provided by Medicaid.
3. New "bidding" processes were established for Part A/B and supplemental benefits, and Part D benefits. CMS now keeps 25% of the savings (the difference between Part A/B revenues and costs), passing 75% to the plans as a "rebate,"

which can be used to pay for supplemental benefits and/or “buy down” premiums for Part D benefits. Under Medicare+Choice, health plans were allowed to use 100% of savings.

4. Prescription Drug Plan (PDP) competitors were created offering stand-alone Part D coverage.
5. New enrollment procedures were instituted, including (a) allowing Medicaid managed care plans to create a companion MA-SNP in 2005 and to “passively enroll” their dual-eligible beneficiaries into the new SNP in 2006, (b) similarly allowing existing Medicare managed care plans to "roll over" existing members into their new MA plan (including SNPs), and (c) "auto-enrollment" into PDPs of dual-eligible beneficiaries who do not sign up for Part D by December 31, 2005.

The demonstration health plans had to accommodate to working in this new policy environment.

The Demonstration states and health plans

The 11 health plans operate under models that differ in the three participating states (Minnesota, Wisconsin, and Massachusetts), but all share several features:

- Open to dual-eligible beneficiaries (either elders, adults age 18-64, or both) on a voluntary basis.
- Risk-adjusted rates (including frailty factors) and full-risk capitation from Medicare and Medicaid. Current frailty adjustors add 15% to 20% to the Hierarchical Coexisting Conditions (HCCs). The adjustors will be phased out between 2008 and 2010.

- Medicaid payments for home-based and community-based long-term care services (HCBS), all or some risk for custodial nursing home care, and full prescription drug coverage.
- Innovative approaches to coordinating medical and social care services.

Minnesota: The Minnesota Senior Health Option (MSHO) program opened in 1997 and is open to all dual-eligible beneficiaries age 65 and over as a more comprehensive alternative to mandated enrollment in a Medicaid-only managed care organization. Three non-profit health plans – UCare, Metropolitan Health Plan, and Medica – contract with a variety of care systems for MSHO services. Individual nurses or social workers coordinate acute and long-term care services. UCare also offers the newer Disability Health Options (MnDHO-PD) program for beneficiaries age 18-64 with physical disabilities. In 2006, MSHO went state-wide, added 6 new health plans, and jumped from 8,000 to more than 30,000 enrollees.

Wisconsin: The Wisconsin Partnership Program opened in 1999 and is open only to dual-eligible community residents who meet nursing home pre-admission criteria. Four very small (less than 1,000 members) non-profit health plans - Eldercare of Wisconsin, Community Care for the Elderly, Community Health Partnership, and Community Living Alliance - contract with individual providers for services. The first two serve elders only, CHP serves both elders and adult disabled, and CLA serves only adult disabled beneficiaries. Service integration is facilitated through teams (nurse practitioner, registered nurse, social worker and others as needed) who work closely with physicians.

Massachusetts: Senior Care Organizations (SCOs) opened in 2004 and are open to all dual-eligible seniors residing in areas served by the participating health plans. Three small plans (less than 2,500 enrollees) contract with a variety of providers for services. Two of the plans are for profit (EverCare and Senior Whole Health) and one is non-profit (Commonwealth Care Alliance). Integration is facilitated through nurse/social worker teams, which coordinate with physicians.

This report presents our findings from (1) semi-structured telephone interviews with senior executives and clinicians in the health plans as well as with state officials, (2) review of health plan documents and (3) the first six months of 2006 enrollment and disenrollment information from the plans.

Impacts of MMA payment changes

Health plans reported that the new MMA bidding tools increased data requirements and administrative demands, added uncertainty to financial outcomes, and reduced flexibility in pooling Medicare and Medicaid to create integrated systems. Although initial results seemed to leave plans with adequate revenues, respondents were cautious about the future, particularly about revenue losses with the phase-out of the frailty adjustor.

Additional administrative time and costs. To complete the new the MA bidding tools, the plans had to create and operate new systems to track and report Medicare and Medicaid costs separately and by service category. Plans relied on their contracted pharmacy benefit managers (PBMs) for their Part D bids, which required factoring their utilization experience into the drug classes and coverage patterns of the CMS formulary and estimating where the membership fell in the Part D subsidy categories. For both bids

they needed to keep up with evolving CMS written guidance and conference calls. Plans had to contract with an actuary to review and sign off on the bid, which was a new cost for small plans. Management, technical, and even clinical staff put in long, stressful hours - particularly in 2005 - to prepare the 2006 bid.

Uncertainty of bidding. Plans reported that bidding was poorly suited for SNPs, especially new and growing ones. They cited higher random risk for small health plans serving high-cost beneficiaries, and their IBNR [incurred but not reported] expenditures fluctuated by as much as 50% month to month. They pointed to inadequate Hierarchical Coexisting Conditions (HCCs) scores for new Medicare dual-eligible beneficiaries, who are started at average HCCs until Medicare cost history is established. Also, plans with significant growth during the year could experience significant shifts in membership risk. Finally, plans placed their extensive care coordination costs in Medicare administrative and service lines, but they feared an audit would disallow this practice, since these are not generally accepted Medicare expenditures.

Coordination with Medicaid. Medicaid capitations continued to cover HCBS, case management, custodial nursing home, eyeglasses and preventive services, and prescription drugs excluded by Medicare (such as benzodiazepines and over-the-counter medications). As the three state Medicaid programs did not break out the pharmacy portion of the capitation, it was difficult for plans to assess if pharmacy revenues from Medicare and Medicaid were higher or lower than those from Medicaid in 2005. Some plans feared that closer Medicare tracking of spending would lead to closer Medicaid tracking, which would reduce flexibility in service provision.

Results of bidding. The goal of all plans was to produce just enough rebate from Parts A/B to pay down the prescription drug premium to zero for plan members, and 10 of 11 plans achieved this. One Wisconsin plan saved too little and ended up with a premium of \$5 in 2006. However, three plans saved too much and "gave back" \$30, \$19, and \$14 per member per month. And even saving just enough means giving money back, e.g., one of the under-65 plans "hit its numbers" by buying down the Part D premium by \$36, from \$64 to \$28, where the low-income subsidy kicked in. To get this \$36 rebate, it had to have \$48 in savings, so it "lost" \$12 on the 25% that CMS kept.

Summary of financial issues. The MMA added many significant and costly new requirements for submitting data on spending, utilization, and Part D benefit status. Since the plans saw little if any benefit from these extra systems and requirements, the term "cost-ineffective" sums up their views of these new burdens. Moreover, respondents feared that stricter financial accounting and the discounted rebate would reduce their flexibility and their incentives to pool funds to pay for new services and benefits, particularly care coordination. Some respondents said that this reduced flexibility, along with the fee-for-service-like tracking of the Part D, were fostering "disintegration on paper." A final financial issue is the phase out of the frailty adjustment. The plans questioned whether HCCs alone will be adequate to account for the actual medical costs of their medically complex members.

Marketing and Enrollment

The Medicare marketplace was transformed by the MMA's provisions for passive enrollment, roll-over enrollment, auto enrollment, Part D co-pays and premiums, and new competition in the form of PDPs, MA-SNPs, and MA-PDPs. The requirement that all

dual-eligible beneficiaries choose or be assigned to one of these options posed new reporting and tracking requirements on CMS. Additionally, to ensure that beneficiaries were well informed about their new options, CMS expanded the www.Medicare.gov website, closely reviewed marketing information, and required plans to maintain information phone lines 12 hours a day, 7 days a week. How these provisions worked out in the states and health plans is discussed below.

Competitive pricing and products. The MMA's Part D co-pay provision (and potential for a Part D premium) removed the advantage these demonstration plans had compared to standard Medicaid in their states, where drug co-pays had been charged. CMS did not allow states to use Medicaid funds to pay the Medicare co-pays, but it was permissible to pay them out of state funds. Minnesota and Wisconsin did not pursue this option, but Massachusetts did. In the first year of implementation, the co-pays did not appear to hamper enrollment in Minnesota and Wisconsin, except at one Wisconsin plan which lost members to its own PACE program, which does not charge co-pays. The one plan that ended up with a \$5 monthly member premium reported that this was not an enrollment barrier.

With the exception of Minnesota, which added new MSHO plans and expanded statewide (see below), new SNPs were not viewed as significant competitors in 2006, but they were expected in 2007. New PDPs were viewed as “more of a nuisance” than real competition, since their benefits were much less comprehensive with no cost advantage.

Retention through roll-over. The initial focus for the plans was to roll over and retain their current members by assuring they did not mistakenly sign up for a PDP during the public information and marketing onslaughts in the fall of 2005. Respondents

said that CMS letters were often interpreted as official government dictates to enroll in a PDP. The CMS-approved language was said to be incomprehensible to many members, particularly frail elders, the disabled, and immigrants.

The plans reached out to members in person, on the phone, and through mailings to make sure their members understood that if they wanted to stay with them, no action was needed, even though other messengers were telling them otherwise. These actions were reported to be very successful, and members of the demonstration plans overwhelmingly chose to stay.

Growth through tested methods and passive enrollment. Having won approval in 2004 to expand MSHO statewide and from 3 to 9 plans in 2006, Minnesota used passive enrollment to grow from 8,000 to 30,000 members in a single year. Each plan continued to focus its MSHO marketing on the members of their companion Medicaid HMO. Marketing was somewhat circumscribed by the requirement that actual enrollment continued to be through county Medicaid offices. Massachusetts' health plans continued to grow by adding new medical groups and territory, and through outreach in ethnic communities. Bilingual employees, translated materials, and development of relationships in the community were said to be keys to growth. As very small health plans, the Wisconsin plans depended primarily on word of mouth and provider referral for new members. Compared with Minnesota and Massachusetts, Wisconsin was limited in growth potential because plan members had to meet prescreening eligibility for nursing homes.

Administrative requirements. More marketing and member information materials needed state and CMS approval than previously, including information on the drug

formularies, changes in provider networks, the Quality Assurance program, a larger Evidence of Benefits, and the medication management therapy program. Although CMS crafted “model language,” it sometimes conflicted with states with respect to the appropriate reading level of member materials and with plans with respect to the scale of their operations (i.e., very small plans did not have a “marketing department”). Despite challenges, all plans reported producing an integrated marketing product.

Maintaining the customer service call center was expensive, and plans reported that it was used mostly by the CMS “mystery shoppers.” These highly integrated plans had “high-touch” member operations already in place, and these calls took time and resources away from genuine client needs.

CMS required all MA and PDP plans to post information on the CMS website (www.medicare.gov), but the site was ill-suited to describe the comprehensive, integrated SNPs. When accessed in April 2007, the site still said that information about the benefits, premiums, and Part D co-pays of the 11 demonstration SNPs was "unavailable." The site therefore gave users no sense that there were comprehensive acute care and long-term care benefits available for zero monthly premium, and in the case of Massachusetts SCOs, without Part D co-pays. This information was available if users linked forward two screens to the plans' websites, but even here the path was not clear since the link was to the Part D portion of the sponsors' sites, and since some of the sponsors had additional Medicare options besides the comprehensive SNP.

Finally, CMS faced administrative requirements of its own, most importantly tracking the Part D decisions (or lack of decisions) of millions of dual-eligible beneficiaries. In the fall of 2005, new SNPs had to report to CMS which of their dual-

eligible beneficiaries were rolled over, passively enrolled, opting out, and newly enrolled. Respondents said that the great majority of demonstration plan members chose to stay. A few chose to enroll in Part D plans by mistake. Others used prescription drug cards that were mailed to them and upon use found that they had been disenrolled from their integrated plan and enrolled in a PDP.

Across the demonstration plans, the CMS tracking success was reported to be as low as 60% at fast-growing plans (the CMS system did not roll over members who joined in the last quarter of 2005) to 95% of intended members. The plans, states, and CMS spent many hours and additional resources to reconcile enrollment, and the financial reconciliation was still ongoing at the conclusion of our interviews the end of June 2006.

Enrollment results. Despite these and other challenges attributed to MMA, all the demonstration plans, with the exception of one small plan in Wisconsin, held onto the bulk of their members on January 1, 2006 and continued to grow for the next 6 months. These findings are summarized below.

Medicare Part D and Pharmacy

Prior to the MMA, the comprehensive demonstration health plans had been offering full pharmacy benefits without co-pays or premiums through Medicaid capitation financing. After the MMA, Medicare Part D took over the bulk of prescription drugs, and Medicaid picked up uncovered drug classes, most notably benzodiazepines, barbiturates, and over-the counter (OTC) medications. For Part D, the MMA radically changed prescription drug financing, benefit structure, and reporting; and the changes had far-reaching effects on the plans, pharmacy networks, and dual-eligible beneficiaries.

First six months of plan enrollment

Wisconsin	December	January	June	Dec-Jan change	Jan-June change
CLA	309	312	323	1%	4%
Eldercare	525	531	577	1%	9%
CCE	301	291	269	-3%	-8%
CHP Elders	524	530	606	1%	14%
CHP Disabled	245	257	299	5%	16%
Minnesota					
Medica	3,206	9,533	9,511	197%	0%
MHP	381	1,005	973	164%	-3%
Ucare -MSHO	4,198	7,294	7,699	74%	6%
Ucare-MnDHO	526	568	672	8%	18%
Massachusetts					
Commonwealth	520	554	770	7%	39%
Senior WH	1,375	1,509	2,220	10%	47%
Evercare	1,214	1,415	1,843	17%	30%

Formulary changes. Part D requires plans to maintain prescription drug formularies within CMS guidelines. The plans reported that MMA resulted in less flexibility for formulary management than under Medicaid. There were more medication restrictions, more mandated changes, and new member notification requirements for changes in formulary, prior authorization drugs, and/or changes in a drug’s quantity limit.

Prescription drug management structures and processes. Most plans reported that the number of drugs subject to prior authorization increased considerably with the implementation of MMA, requiring additional personnel or additional costs of PBM services. A time-consuming new requirement for health plans and pharmacists was the need to ensure the correct assignment of prescriptions to either Part B versus Part D,

depending not on the drug but on the circumstances of the prescription. Additional accounting and payment challenges accompanied member transitions from a nursing home (Part B coverage) to the community (Part D). The impact of this extra work was viewed as ongoing rather than transitional.

Staffing and additional reporting requirements. Almost all of the health plans hired additional personnel to manage the Part D benefit, including pharmacists and pharmacy technicians to handle the increase in prior authorization volume. Additional staff resources were needed to keep abreast of extensive CMS guidance via teleconferencing meetings, e-mail communication, etc. Many plans had to develop system modifications to track the low income subsidy, true-out-of-pocket costs (TrOOP), and other member-level details to accurately manage the Part D benefit.

Changed relationships with PBMs and pharmacies. Whether plans were working with previously contracted PBMs or newly contracted PBMs, new MMA-related services were required at additional cost to the plans such as increased prior authorization and frequent, extensive reports. Most of the health plans reported maintaining or expanding their pharmacy networks, although several plans reported it was becoming increasingly difficult for small pharmacies to compete at the lower prices offered by national chain pharmacies. Small pharmacies were said to be assets to these health plans and members by providing extra services, such as insulin pre-fills and home delivery. Chain pharmacies were generally unwilling to offer these services, or to create alternative billing approaches for Part D co-pays.

Medication Therapy Management (MTM). The MMA mandated a Medication Therapy Management program (MTM) for individuals with projected medication costs

above \$4,000 annually and/or concurrently taking six or more medications. MTM is intended to improve medication use and reduce adverse drug events. All of the demonstration health plans had medication review and intervention as part of their ongoing care management prior to MMA, so meeting this requirement involved formalizing existing systems for medication review, documentation, and reporting. Many of the health plans implemented the MTM program within the plan rather than via contracting as they recognized the benefit of additional medical claims data for identified MTM members.

Member access and co-pays. All plans implemented coordinated, comprehensive efforts to assist members with the transition to MMA. These efforts, combined with the relationships members had with plans, were reported to have been successful in insulating them from some of the problems experienced by other Medicare beneficiaries in terms of access to prescription drugs. All plans expressed concern that the MMA's required co-payments (\$1/\$3 or \$2/\$5 per prescription depending on generic or brand and Medicaid eligibility level) would negatively affect access and compliance, but at the time of our interviews none of the plans reported significant problems with the payment or collection of co-payments. A few plans reported increases in generic dispensing as a result of revised formulary management, but the plans reported that it was too early to determine definitive changes in utilization as a result of MMA.

Summary

Cost-ineffectiveness. The greatest impact of the MMA on the demonstration health plans was the need for additional staff and resources to manage the new MMA regulatory requirements, particularly the administrative requirements of the bid process

and the ongoing reporting for Part D. During the months leading up to bid submission, managers, IT departments, pharmacists, and even clinicians at the smaller plans worked late nights and weekends on administrative work not related to improving or delivering care. They had to hire actuaries and increase time to PBMs to meet MMA requirements. Given the limited, if any, value that plans and beneficiaries experienced from these changes, the MMA appears to be a high-cost, low-value reform for these dual-eligible plans.

Disintegration on paper. Plan managers also worried that the closer accounting of Medicare funds would lead Medicaid to do the same, resulting in decreased flexibility to pool capitations to create innovative services and care systems. Key to this is how to pay for the care coordination services that are an essential component for these fully integrated health plans. While all plans reported that CMS accepted the placement of care coordination in Medicare administrative or direct service lines, concern was expressed about future audits. Respondents also said that the need to pay for supplemental services with discounted rebate dollars reduced incentives to use innovative methods to try to cut utilization of Medicare services.

Part D was another source of disintegration. Part D fragmented the comprehensive prescription drug benefit that these plans operated under the Medicaid program. They had not had to make the distinction between Part B and Part D medications, to report on MTM, or to track and report on TrOOP, LIS, and co-payment status on all members. Nor had they had mail this information to members monthly and then take time explaining that it was very unlikely to apply.

Impacts on beneficiaries. The good news is that the demonstration plans were generally successful in shielding their members from the confusion and potential dislocation of the MMA changes. They used their close relationships with members to help them make informed decisions about Part D (usually to stay with their comprehensive plan). They worked closely with pharmacies, states, and CMS to make sure that those who disenrolled by mistake were covered until they were re-enrolled, and to make sure that the right Part D co-pays were charged, or that drugs were not denied due to inability to pay co-pays. The plans also maintained their comprehensive benefits and integrated service systems under the new financial and regulatory structures, despite fears that this might not be sustainable over time. The major change was that dual-eligible beneficiaries in the plans faced new co-pays (except in Massachusetts), which could be significant for an individual with 13 prescriptions a month (the mean for plans serving adult disabled beneficiaries). And finally, with one exception, the plans held onto their old members in the transition, and they continued to add new ones.

Future policy issues. These prototypes for comprehensive dual-eligible SNPs provide tested and practical models for the MA program to serve beneficiaries who are among its most vulnerable and costly. The plans survived the transition to the predominant Medicare managed care program, including offering the Part D benefit; but how they survive, and how their comprehensive and integrated service models evolve in the context of the MA program in the next few years remains to be seen. Their special payment supports are being phased out, and there are no requirements in the current MA SNP model that they maintain their integrated, comprehensive service systems. Will these plans fend for themselves and make their own decisions about their futures,

including the real possibility that they will phase down as comprehensive dual eligible plans? Or, will the MA program evolve to incorporate successful features of these models in the dual-eligible SNP option? The latter course would allow not only for a continuation of these three states' and eleven health plans' models of integrated Medicare and Medicaid services, but also encourage other states and plans to emulate their approaches over time - without need for special demonstration authority.

I. Background

This study was conducted under a contract from the Centers for Medicare and Medicaid Services (CMS) to accomplish two aims: (1) evaluate lessons learned from 11 demonstration health plans that offer comprehensive managed care for individuals who are eligible for Medicaid or both Medicare and Medicaid, and (2) assess the impact of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the MMA) on the operations of these plans. A separate report has been completed on the first aim (Bishop, Leutz et al. 2006), and this report addresses the second, with particular focus on MMA impacts in three areas: finances, marketing, and prescription drugs.

A. MMA Provisions Affecting Comprehensive Dual Eligible Health Plans

The MMA transformed and expanded the Medicare + Choice (or Medicare Part C) plans established by the Balanced Budget Act of 1997. Medicare + Choice plans (and their predecessor TEFRA plans) afforded seniors the opportunity to participate in managed care organizations and reduce out-of-pocket expenditures and Part B premiums and obtain preventive health services and additional benefits not traditionally covered under Medicare. The MMA not only changed the name of these health insurance plans to Medicare Advantage (MA) plans, it made a series of substantive changes, some of which have unique relevance to health plans offering comprehensive benefits to dual-eligible beneficiaries. Five areas stand out.

- A Special Needs Plan provision. Special Needs Plans (SNPs) are defined as MA coordinated care plans that exclusively or disproportionately serve special needs individuals. Three types of Medicare beneficiaries are eligible for enrollment in a

SNP: beneficiaries residing in institutions, beneficiaries entitled to health benefits under Title XIX (Medicaid), and other beneficiaries with severe or disabling conditions who would benefit from enrollment in a SNP. Under Medicare payment and Medicaid waiver authorities, the States of Minnesota, Wisconsin and Massachusetts developed demonstrations that integrate Medicare and Medicaid financing to coordinate and simplify service delivery between primary, acute and long-term care providers. Services are delivered through fully capitated private managed care plans. Under MMA, these demonstration dual-eligible plans were transitioned into one or another of the SNP categories.

- A new Medicare prescription drug benefit (Part D). The benefit covers some but not all of the drugs covered formerly by Medicaid for these plans, and this now puts Medicaid in the position of supplementing the Medicare benefit with uncovered drugs, e.g., benzodiazepines and over-the-counter. The Part D benefit also requires all beneficiaries to pay co-pays on prescriptions, a charge that members of these plans did not face previously. The benefit also has a required formulary and introduces extensive new tracking and reporting requirements for health plans.
- New Medicare benefit development and payment approaches. Projected costs and revenues for Part A/B and supplemental benefits, and for new Part D benefits, are calculated and submitted separately on new CMS "bidding tools." On the bid for Parts A/B, CMS now keeps 25% (rather than none) of the savings (the difference

between Part A/B revenues and A/B costs) and leaves the plans with 75% (now called a "rebate"). Plans can use rebate dollars not only to pay for traditional supplements but also to "buy down" premiums for Part D benefits that may result from calculations using the Part D bidding tool. If the demonstration plans wanted to maintain a zero premium for their dual-eligible members, they had to allocate enough rebate to pay the anticipated premium.

- New Prescription Drug Plan (PDP) competitors. Under the MMA, Medicare beneficiaries can receive their Part D benefit either from MA plans or new PDPs, which offer stand-alone Part D coverage. The new benefit spurred large numbers of PDPs into most market areas, each with multiple price and coverage options. The combination of PDP marketing, plus a mandate for Medicare beneficiaries to choose a Part D option or face a financial penalty, led to a barrage of information aimed at beneficiaries. The demonstration plans had to get the message across to their members that they were not required to choose another Part D option, since they were already enrolled in a qualifying plan.
- Passive enrollment. The MMA allowed existing Medicaid managed care plans to create a companion MA SNP and to "passively enroll" their dual-eligible beneficiaries into the new SNP. Medicaid enrollees were given the option to opt out or to be automatically enrolled in the SNP. This provision was especially important for the Minnesota demonstration plans, since CMS had allowed the State to expand its dual eligible demonstration statewide. With passive

enrollment, the three health plans in the demonstration were allowed to offer passive enrollment to dual-eligible beneficiaries in their Medicaid HMOs. Also, six additional existing Medicaid HMOs were allowed passively enroll their Medicaid HMO members into new SNPs. The demonstration plans in Wisconsin and Massachusetts that already had Medicare contracts had essentially the same process to "roll over" their members to their MA SNPs: inform them of their option to switch or to do nothing and stay. This roll-over procedure was also used by Minnesota dual-eligible plans for their existing members.

Details of MMA provisions and CMS regulations in each of these areas will be discussed in the sections below on finance, marketing, and prescription drugs. The next introductory section describes the three comprehensive dual-eligible demonstration initiatives.

B. The Demonstration Health Plans as Comprehensive Special Needs Plans

A primary goal of the new MA SNPs is to control the escalating health care expenditures of high-risk beneficiaries via focused, comprehensive care delivery models. Nearly a decade before the MMA, three states initiated Medicare/Medicaid demonstration projects for comprehensive care models via the integration of Medicare and Medicaid benefits (GAO 2000). These models now look like prototypes for a comprehensive approach to MA SNPs.

The State of Minnesota implemented the first demonstration model as the Minnesota Senior Health Options (MSHO) in 1997, followed in 1999 by the Wisconsin Partnership Program (WPP). In 2001, Minnesota added Minnesota Disability Health Options (MnDHO-PD) for physically disabled Medicaid beneficiaries or full-benefit dual-eligible beneficiaries who are 18-64 years of age. The final state to implement the fully integrated Medicare and Medicaid model was Massachusetts with the MassHealth Senior Care Options initiative in 2004.

While the demonstration models have unique infrastructures and characteristics, their common foundation is a fully integrated, coordinated service delivery system for Medicaid-only and full-benefit dual-eligible beneficiaries. These integrated systems encompass Medicare acute care services, as well prescription drugs (covered fully by Medicaid until 2006), institutional and community-based long-term care services, coordination of acute care and long-term care, and a range of ancillary services. Most programs enroll only those over 65 years of age, but some serve younger adults with disabilities. Operating under a Medicare payment waiver and a range of Medicaid waiver authorities, the plans pool capitated payments from Medicare and Medicaid to finance these standard services. A key payment component of the models tested in the demonstration was frailty-adjusted payments from both Medicare and Medicaid. Details of these provisions will be related presently.

In Minnesota, MSHO is open to Medicaid-only and all full-benefit dual-eligible beneficiaries in participating counties as an integrated alternative to mandated enrollment

in a Medicaid-only managed care organization (Prepaid Medical Assistance Plan, or PMAP). Between 1997 and 2005, three non-profit health plans – UCare Minnesota (UCare) , Metropolitan Health Plan (MHP), and Medica – contracted with a variety of care systems for the provision of MSHO services; and a care manager facilitated service integration and coordination. UCare also offered the MnDHO-PD program serving adult beneficiaries ages 18-64 with physical disabilities through a sub-contract with AXIS Healthcare. In 2005 the demonstration was expanded statewide and to a total of ten health plans, and by early 2006, MSHO was serving more than 30,000 enrollees.

The Wisconsin Partnership Program (WPP) is open only to dual-eligible community residents who meet nursing home pre-admission screening criteria (nursing home certified - NHC) and reside in the participating counties. Four very small (less than 1,000 members), non-profit, specialized health plans (Eldercare of Wisconsin, Community Care, Community Health Partnership, and Community Living Alliance)¹ contract with individual providers for services. Service integration and care coordination are facilitated through teams (nurse practitioner, registered nurse, social worker and others as needed) who work closely with community physicians. Two of the health plans enroll only seniors, one enrolls only disabled adults, and one enrolls both.

MassHealth Senior Care Options is open to all dual-eligible seniors who reside in areas where senior care organizations (SCOs) are located. Three small SCOs (less than 2,500

¹ These are the public names of the programs. The formal names of the health plans that hold the contracts with the state and CMS are respectively, Elder Care Health Plan, Inc., Community Care Health Plan, Inc., Partnership Health Plan, Inc., and Health Plan for Community Living, Inc.

members) contract with a variety of providers (including community health centers) for the provision of services. Two are for-profit plans (EverCare and Senior Whole Health), and one is non-profit (Commonwealth Care Alliance). Integration of services is facilitated through teams comprised of a nurse and social worker (the latter contracted from the state aging services access program - the state home care system) per statutory requirement. They bring primary care physicians into the team in various ways depending on member needs and number of members served by the physician.

Table 1 summarizes the characteristics of the three state models, and Table 2 shows the individual health plans and the areas they serve. More detailed characteristics of the health plans and their memberships are found in our previous report.

II. Methods

In a previous Brandeis report (Bishop, Leutz et al. 2006), we described these 11 health plans, based on case studies of each plan, with the intent of highlighting some exemplars for the newly approved MA-SNPs entering the marketplace in 2006 and 2007. Based on this earlier research, three domains of interest were identified as key to evaluating the impact of MMA on their operations: the financing/bidding process, marketing/enrollment, and prescription drug benefits. We conducted semi-structured telephone interviews around these primary domains with senior management from the 11 health plans, as well as with state Medicaid officials. Interview respondents at each plan included the project director and staff members responsible for clinical care, finance, and marketing. In Minnesota the new MSHO plans were not included since they were not

operating when Phase I of the study was performed, and adding them for this phase was beyond the scope of work included in the contract with CMS. Phone interviews were performed between May and September of 2006. To provide understanding of the MMA's impact on sites' capacities to hold on to membership and grow, we additionally collected enrollment and disenrollment data for December 2005 and the first six months of 2006.

Table 1: Integrated Special Needs Plans (2006)				
	Minnesota Senior Health Options	Minnesota Disability Health Options - Physically Disabled	Wisconsin Partnership Plan	Massachusetts Senior Care Options
Contracting health plans	Large non-profits	Large non-profit	Small, specialized non-profits	Small and large for-profits and non-profit
Target market	Community residents (NHC and non-NHC); Nursing home residents	Community residents (NHC and non-NHC); Nursing home residents	Community residents (NHC only)	All MassHealth seniors, age 65 and over (NHC and non-NHC and NF residents)
Age groups served	65+	18-64 (but may remain in plan when turn 65)	Under and over 65	65+
Care coordination model	Nurse or social worker care coordinator	Nurse-social worker team	Inter-disciplinary team led by nurse practitioner	Nurse-social worker-PCP team

The focus of this follow-up report is the impact of the MMA on these 11 demonstration contractors. Under MMA, the plans were approved as MA-SNPs in 2005; they began operating as SNPs in 2006; and their Medicare waiver provisions continue through the

end of 2007. The remainder of this report highlights the challenges these organizations faced in becoming MA SNPs, the approaches they took to face these challenges, and their success in maintaining integrated, comprehensive benefits and their market positions.

Table 2: Plans, Service Areas, and Profit Status (2006)				
<u>A. Service areas, plan types, and enrollees served</u>	Service area	Profit Status	Enrollees served	Total enrollees (December 2005)
Minnesota				
Metropolitan Health Plan (MHP)	5 counties	Non-profit	65+	381
Medica	33 counties	Non-profit	65+	3,206
UCare (MSHO)	55 counties	Non-profit	65+	4,198
UCare & AXIS Healthcare (MnDHO-PD)	Twin cities area	Non-profit	Adult physically disabled ages 18-64 (but may remain in plan when turn 65)	537
Wisconsin				
Eldercare of Wisconsin (ECW)	Dane Co. (Madison)	Non-profit	55+	525
Community Care (CC)	Milwaukee & Racine	Non-profit	65+	301
Community Health Partnership (CHP)	3 rural counties near Eau Claire	Non-profit	65+ & Adult disabled	769
Community Living Alliance (CLA)	Dane Co. (Madison)	Non-profit	Adult disabled	309
Massachusetts				
Commonwealth Care Alliance (CCA)	Metro Boston, Springfield, North Shore	Non-profit	65+	520
Senior Whole Health (SWH)	Metro Boston, Fall River, Brockton	For-profit	65+	1,375
Evercare SCO (ESCO)	Metro Boston, Merrimack Valley, Worcester	For-profit	65+	1,214

III. Finances: Balancing the Medicare Bidding Process with Medicaid Capitation

A. Relevant MMA Provisions

The MMA changed several provisions for how health plans report their costs of delivering Medicare and supplemental benefits, and how revenues are subtracted from costs to determine allowable member premiums. The MMA follows M+C and TEFRA in requiring (1) that any surplus of Medicare revenues after deducting the estimated cost of delivering Medicare-covered services must be returned to beneficiaries in the form of additional benefits or reduced Part B premiums, and (2) that additional member premiums can be charged only after showing that there are uncovered costs after all Medicare revenues have been applied to allowable service and administrative costs.

There are two important new provisions, however. First, the MMA mandates that CMS keeps 25% of the difference between A/B revenues and A/B costs, leaving only 75% for health plans to pay for the cost of supplemental benefits (the 75% share is now called a "rebate"). Formerly, health plans were allowed to apply 100% of savings to supplements. Second, under the mandate, health plans must charge member premiums for costs that are in excess of Medicare revenues. Under M+C, health plans could forego premiums if they chose, and many did in order to maintain a competitive market position.

Bidding would not be so difficult an exercise if the task were only to project costs for Parts A/B plus supplemental benefits and to compare that to Part A/B revenues. The

payment rates by county are still published; there are rules for entering cost and utilization experience; and each plan's case-mix adjustors are known. The submission is called a "bid," but all the parameters are known if a health plan has experience.

What has made this more than an exercise, especially in the first year of the MMA, is the fact that the A/B bid is linked to the new Part D bid, and the Part D revenues are set through a real bidding process in which the Part D "benchmark" (the market-determined cost for delivering the standard benefit to the average beneficiary) is not known in advance. Rather, the benchmark is determined after all MA plans and PDPs have submitted their bids. This benchmark is largely established by large for-profit PDPs that primarily serve beneficiaries who are not dual-eligible and do not, on average, incur the high drug expenditures of beneficiaries served by the integrated health plans in this demonstration.² If the estimated actuarial cost of delivering a plan's Part D benefit (adjusted by case-mix factors) is above what the benchmark produces for the plan in revenue (adjusted by case-mix adjustors, low-income subsidies, and other factors), the plan is required to charge a member premium for the difference. Again, this premium cannot be foregone by the plan, but it can be "bought down" through excess A/B revenues. Thus plans need to adjust their A/B supplements to produce the amount of surplus (rebate) needed to get the Part D member premium to a level where they can compete in the market. If the plan sets aside more rebate than it ultimately needs to pay the Part D premium down to zero, it cannot re-allocate those funds to other benefits. CMS keeps the money.

² During our interviews with the health plans, several indicated their dissatisfaction with the fact that their bids were not included in the benchmark calculation.

Informants said that the significance of these calculations for health plans serving dual-eligible beneficiaries under concurrent Medicare and Medicaid capitations was three-fold:

- Dual-eligible beneficiaries may be unwilling (or unable given the level of their poverty) to pay any monthly premium, especially if there are zero-premium Part D options available in their locale. To be safe, the demonstration health plans tended to allocate more rebate than was actually needed to cover the Part D premium, leading to "giving back" money to CMS. If they did not allocate enough rebate, they could end up with a member premium, which could affect their market position.
- The demonstration plans had to decide (and CMS had to approve) how to allocate the costs of care coordinators (generally nurses or social workers) between Medicare administrative costs, Medicare service costs, supplemental services, and Medicaid.
- Even after covering care coordination costs and the Part D premium, health plans may not have enough supplemental service costs to use the full rebate. This is because Medicaid covers most of the benefits that are often offered in supplement packages (e.g., eyeglasses, dental, uncovered Part D). Some plan managers were unclear if CMS would approve proposals for extra services or to use savings to pay for what Medicaid might typically cover.

All of these dynamics could result in a reduction of health plans' excess A/B revenues compared to pre-MMA reimbursement policies.

The health plans were queried regarding three primary themes within the financial/bidding process domain: (1) the Medicare bidding processes for 2006 and 2007; (2) revenues compared with revenues prior to MMA and Part D; and (3) effects on overall plan operations, especially related to the integrated features in these health plans.

B. Findings Related to Finances

1. The Bidding Process

The bidding tools and associated guidance from CMS were developed in 2004 and first implemented in 2005 for the 2006 bid. The experience was a new one for both CMS and health plans, and there was a good deal of "making it up" and "making it over" as the bidding process went along. By the time the work on the 2007 bid began in 2006, the plans were prepared for the process, but the work was still substantial, on short timelines, and tense due to unknown outcomes.

Health plans reported that they were frustrated at the demands of bidding, but they generally understood and sympathized with the magnitude of the challenges that CMS faced and largely solved.

The demonstration plans reported that the MMA bidding process affected them most in four areas: (1) additional time and administrative spending to put together the bid; (2) uncertainty from bidding with inadequate data; (3) the results of the bid; and (4) how Medicaid payments related to the Medicare bid and revenues.

These impacts were experienced by all plans, but there were differences that tended to split by the size and experience of the plan.

Administrative time and costs. The bidding process was challenging for almost all of the plans, especially in the preparation of estimates of service costs for the 2006 bid. Prior to the MMA, the demonstration plans pooled Medicare and Medicaid revenues to pay for comprehensive Medicare and Medicaid benefits and services. The theory of the integrated care models was that utilization of expensive hospital and nursing home services would be reduced through substitution of less expensive care coordination and community-based services and supports. These latter services were financed through the pooled capitations without much specific tracking of "who" was paying for what. Similarly, while the bulk of pharmacy benefits were covered by the Medicaid capitation, and the Medicare capitation covered the small amount of Part B drugs, there were no requirements that health plans track or report the costs of delivering these separate benefits.

The MMA bidding systems appeared to the health plans to threaten this pooling arrangement by introducing a much closer tracking of expenditures of Medicare revenues. All of the demonstration health plans reported that tracking and reporting of expenditures for the bidding process resulted in significant additional costs, and most saw little if any added value. The areas of new work included developing the capacity to separate, track, and report on distinct parts of Medicare benefit and administrative costs, and in the case of the dual-eligible plans, wrap-around and supplementary Medicaid

services as well. New distinctions to make in tracking included Medicare versus Medicaid (co-pays and deductibles) portions of A/B benefits; Medicare Part D, Medicare Part B, and Medicaid parts of prescription drug benefits; Medicare versus Medicaid administrative costs; and the status of each member beneficiary in relation to where they stand in Part D coverage categories.

In 2005, information system staff, top administrators, and even medical staff at some sites became heavily involved in developing ways to extract and interpret data, and to make estimates of utilization and costs for the required reporting categories. For Part D bids, the sites generally relied heavily on their contracted pharmacy benefit managers (PBMs) to analyze their utilization experience in the formulary, coverage, and subsidy categories. The plans reported that the PBMs did not charge extra fees for this work, but it was certainly built into their overall rates. It is worth noting that these plans were probably among the few MA plans across the nation operating at full risk for pharmacy prior to Part D as a result of their capitated Medicaid pharmacy contracts prior to 2006. Additionally, all plans were required to have an actuary review and sign off on the bid as being sound and reasonable. Prior to the MMA, the small plans did not contract with actuaries, and this cost was therefore new to them (reported by the Wisconsin Partnership plans at between \$40,000 and \$50,000).

In 2006, plans were more prepared for the 2007 bidding process. They developed and used new reporting and tracking systems to separate costs into the Medicare bidding categories. Some plans requested providers to bill separately for Medicaid/Medicare

services in 2006, something they had not needed before. This resulted in increased work for the providers and substantially increased claim processing internally, but it made bidding easier and more accurate. One area of claims "adjudication" that continued to bedevil many plans was the separation of prescriptions into Part B, D, and Medicaid.

In addition to the administrative costs associated with preparing bids for 2007, plans had to spend considerable time and expense meeting other new administrative requirements of the MMA. Described elsewhere in this report, these extra administrative tasks included completing required reports under Part D, advising members of changes brought by the MMA, participating in scheduled CMS guidance calls and reviewing guidance materials, and meeting CMS call center requirements. All these new costs were added by plans to their administrative lines in their bids. When asked whether there was any added value from these new requirements, the uniform answer from the plans was "no." Beyond the cost impacts, the plans said the new process created "disintegration on paper," making it more difficult to move Medicare revenues and to pool Medicare and Medicaid revenues toward administrative and clinical functions that integrated care.

Adequacy of data and guidance. The MA bidding process requires health plans to submit their bid in early June of the year before the contract year. Given the lag in payments of claims, this means that a plan's bid for calendar year 2007 is based almost entirely on data from calendar year 2005. Of course, all MA plans face this problem of "old" data, but the dual-eligible plans in the demonstration reported special challenges to making accurate bids. These related to:

- The small size and high costs per member of most of the demonstration plans.
- Inadequate rates for newly eligible Medicare beneficiaries.
- Anomalies in how to bid for beneficiaries who join during the year.
- Questions about how to classify care coordination costs.
- How to bid when a plan is growing quickly. The SCO plans in Massachusetts also had the disadvantage of bidding based on limited experience.

Bidding with small size and high average costs: Small plans with relatively small numbers of high-cost members believed they were particularly vulnerable to making inaccurate bids. First, small size simply creates more room for random error. Second, their respective IBNR (incurred but not reported) expenditures may increase as much as 50% month to month.

Bidding on newly eligible Medicare beneficiaries: As Medicaid beneficiaries “age-in” to Medicare eligibility, or as they gain eligibility for Medicare in the disabled category after their two-year eligibility waiting period, plans reported that the Medicare risk adjusters were inadequate. These new-to-Medicare beneficiaries are assigned base rates for average beneficiaries regardless of the actual presence of disease conditions. This has a differential effect on plans targeting dual-eligible beneficiaries who have, in general, higher rates of illness and disabilities than average. Because plans with companion Medicaid HMOs also served Medicaid-only beneficiaries, they said they could back up this pattern, since they had the Medicaid utilization and diagnostic data. For example, two Minnesota plans reported that their new-to-Medicare members without scores on the

Hierarchical Coexisting Conditions (HCC) reimbursement system were assigned low HCCs: under 1.0 at one plan and 1.052 at another, versus their plan averages of 1.43 and 1.55 respectively. One of the plans serving under-65 Medicare disabled beneficiaries had to enter HCCs for newly eligible beneficiaries at .8 to .9 - far below their 1.53 plan average.

Bidding while growing: Another problem with the bid process expressed by these integrated plans was the projection of a bid based upon membership at a single point in time. Dual-eligible plans, unlike post-MMA MA plans, have continuous open enrollment. For a plan that is growing throughout the year, this can result in significant shifts in membership risk after the bid is submitted and accepted by CMS. One plan explained this scenario as follows. The bid pricing tool instructions suggest that a plan should enter its own expenditure history and categorize its members based on their period of enrollment in the specific plan. The Part D Bid Pricing Tool asks for four data elements (number of members, member months, the total number of prescriptions, and annual drug spending) for members in each level of spending (deductible, co-pay, donut hole, and reinsurance). If a plan enters its actual data, the members must be classified according to their drug expenditures during their enrollment with the plan, not the members' annual enrollment in all plans. (Attempting to enter actual data, but classified according to the projected annual spending, produced a reported error in the Bid Pricing Tool.) In cases of rapidly growing enrollment, this methodology was reported to result in a substantial increase in the plan's projected expenses for members in the benefit level where the plan was at risk. This is because the member has only a few months to reach

each successive benefit level, particularly the “donut hole” and reinsurance levels. As a result, the plan’s bid would be substantially inflated above the benchmark. Unless corrections are made in these calculations, the impact of this error on plans may have been significant.

Bidding with high care coordination costs: As described above, the MMA bidding tool required that Part A/B revenues be used first to cover A/B services, deductibles, coinsurance, and administration, and that only 75% of leftover revenue would be returned to health plans in the form of a "rebate." Because the demonstration plans were using a variety of types of care coordination that potentially could reduce the use of Medicare

services, it was important for them to be able to have these considered as either Medicare services or covered Medicare administrative costs, rather than having to pay for them with discounted rebate funds and offer them as supplemental services.

There could be a lesson here for other MA plans that are interested in enhancing care coordination: Putting these services "above the line" in Medicare administrative or service costs makes them more affordable, and not having to describe them in marketing materials as supplemental services may reduce the risk

Putting these services "above the line" in Medicare administrative or service costs makes them more affordable, and not having to describe them in marketing materials as supplemental services may reduce the risk of adverse selection and related competitive disadvantage.

of adverse selection and related competitive disadvantage. Besides not being typical Medicare services, health plans also had to consider whether coordination could be considered a Medicaid service, since Medicaid does cover care coordination costs in home-based and community-based (HCB) services waiver programs. However, waiver

care coordination typically covers the coordination of HCB services, not the coordination of medical care or the coordination of medical care with HCB services, as happens in these comprehensive health plans.

CMS allowed the dual demonstration sites to include costs for care coordinators in Medicare administrative and service lines in 2006 and 2007, and sites used various methods to allocate the costs: One Minnesota site put most of its care coordination costs in Medicare administration, while another put the costs in Medicare services. One Wisconsin site put nursing assessments by phone in administrative costs, while assessments in person went into clinical costs. One Massachusetts site put its nurse coordinator time in medical services since all but one of its coordinators were stationed in medical groups; the cost of the social worker contracted from the Area Agency on Aging went into administration. Another Massachusetts site put a percentage of its care coordination costs in administration, the percentage determined by the share of its total revenues coming from Medicare versus Medicaid. All these decisions seemed reasonable and defensible to the respondents, and they were not questioned by CMS. However, given the lack of clear guidance, and the significance of these costs, particularly at the Wisconsin sites, health plans reported that they still feared that their allocations would be questioned in an audit.

Bidding while new. Finally, projections for both the 2006 and 2007 bids were based largely on information on pre-MMA medical costs. While Minnesota and Wisconsin had lengthy histories of actual medical expenditures to make credible bid projections,

Massachusetts plans had at most 18 months of plan experience prior to MMA. This had significant effects on the credibility of their data and their confidence in their bids.

The MSHO and Wisconsin Partnership plans had five or more years of experience to assist with the 2006 bid process, giving them "credible" data in actuarial terms. .

Inpatient, outpatient, and pharmacy utilization data were strong among all plans.

Additionally, for MSHO plans, good data were available on beneficiaries who were passively enrolled into MSHO from the sponsor's PMAP plan. This greatly assisted plans with preparing their bids. Since it started more recently, the MnDHO product did not have enough experience yet to develop precise bid projections.

In contrast, the Massachusetts SCO programs were not implemented until August 2004, and all SCOs lacked the required twenty-four months of health plan experience to "credibly" project Part A and Part B costs. Consequently, particularly for the 2006 bid, the plans and their actuaries drew on data from a variety of sources in addition to their own (e.g., similar populations in other states, data from affiliated health systems, MSHO data, and data from their consulting actuaries). For their members meeting NHC criteria, they used the Massachusetts Program for All-inclusive Care for the Elderly (PACE) sites' average of 0.30 for the frailty factor³. For Part D, Massachusetts sites feared that limited historical claim data on members relative to the bid had the potential to create an artificial inflation in the bid, especially for their rapidly growing health plans. Plans had three months of actual experience under MMA to prepare the 2007 bid, but they did not feel

³ See discussion of bidding results in next section for an explanation of the frailty factor.

that these data were valid due to incorrect enrollment information⁴, ongoing cost reconciliation with CMS, and incomplete claims as a result of the inherent lag time in claim submissions. The incorrect enrollment information was the result of widespread data processing difficulties associated with the initial transition to Part D.

2. Bidding results

Since the collection of data for this report ended before sites had the results of their bids for 2007, we can report only on the results for the 2006 bid. Results on which the sites were able to comment included the accuracy of their bids, the adequacy of risk adjustment, the adequacy of revenues, and enrollment errors and revenues.

Accuracy of the bids. The goal of plans in the bidding process was to allocate just enough rebate to buy down the Part D premium to zero. Allocation of more than was needed meant giving money back to CMS. Most plans reported that in 2006 they either hit their targets or came very close to doing so. Only one plan (in Wisconsin) ended up with a premium, and this was only \$5. The plan leadership said they could have made adjustments to "make it go away," but they decided not to in order to see if they could market a plan with a premium (see the marketing section for a discussion of their generally successful results). On the other side, several plans reported having to "give back" rebate in 2006. One of the Minnesota plans said it "left \$30 (per member per month) on the table" from making a bad guess on the low-income benchmark. Two of

⁴ See section IIB2 below.

the Wisconsin plans gave back \$19 and \$14. The Massachusetts plans all reported hitting their goals. Another aspect of the "give back" that is in addition to these numbers is the loss of revenue with the new rebate structure. For example, one of the under-65 plans that "hit its numbers" did so by buying down the Part D premium by \$36, from \$64 to \$28, where the low-income subsidy kicked in. To get this \$36 rebate, it had to have \$48 in savings, so it "lost" \$12 on the 25% that CMS kept.

Risk adjustment. These plans all had HCC scores substantially higher than the Medicare average of 1.00 (ranging for the 2006 bid from 1.43-1.56 for Minnesota sites; 1.91-2.36 for Wisconsin elderly sites; 2.05 for Massachusetts sites; and 1.53-2.28 for under-65 disabled sites - see Bishop et al. 2006 for details). The plans reported the importance of accurate member diagnostic coding to maximize revenues, and one Wisconsin plan employed an HCC Coordinator and Data Analyst solely dedicated to managing the HCC risk model. The HCC Coordinator worked closely with primary care and nurse practitioners to ensure the comprehensive, accurate coding of all member diagnoses.

Most sites reported that they did better under payment with frailty-adjusted HCCs (FA-HCCs) than with the NHC-AAPCC demographic formula, which is being phased out. The 2006 bid split payments 50-50 between FA-HCCs and NHC-AAPCC, and the 2007 bid was prepared with 25% NHC-APCC adjustor and 75% FA-HCC adjustor.

Even if the new frailty factors were offered to the state dual-eligible plans, they provide much lower additions to payment for frail beneficiaries than the old factors. As detailed in

our prior report, frailty adjustments were a significant help at all sites (adding 0.15-0.21 to HCC scores at the Minnesota sites; 0.39-0.45 at the Wisconsin elderly sites; 0.30 at the Massachusetts sites; and 0.45-0.70 at the under-65 disabled sites, where the frailty adjustments applied only to members age 55 and older). For three sites the addition of the frailty factors increased Medicare revenues by 10% to 15%; for six sites they increased revenues 19% to 20%; and for one site (an under-65 disabled plan) they increased revenues 45%. Similar figures were reported for the 2007 bid. Some of the Massachusetts plans reported that they were enrolling less sick beneficiaries and expected to see their respective frailty adjustors reduced.

On February 16, 2007, CMS issued an Advance Notice that the FA-HCC frailty adjustors would be phased out between 2008 and 2010 for these demonstration health plans. In

2008, payment will be weighted at 75% with the frailty formula and 25% with regular HCCs. Weights move to 50/50 in 2009, 25/75 in 2010, and 100% regular HCCs in 2011. Newly calculated frailty factors were announced in the Advance Notice, but they will be available only to PACE in 2008. Even if the new

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factors were offered to the state dual-eligible plans, they provide much lower additions to payment for frail beneficiaries than the old factors. The FA-HCC and the NHC-AAPCC have not been available to other new SNPs.

Adequacy of revenues. The MMA could affect the demonstration plans' revenues in two major areas: the loss of 25% of Part A/B savings through the rebate mechanism

(discussed above), and the change in pharmacy revenues from the transfer of most revenue from Medicaid to Medicare.⁵ Most of the plans reported that it was too early to determine if pharmacy revenues from Medicaid plus Medicare in 2006 were higher or lower than Medicaid revenues in 2005. The ability to know was also hampered by the fact that in all three states the Medicaid capitation did not break out payments for the pharmacy supplement from other services. Plans reported that this uncertainty may be offset by a reduction in risk for pharmacy costs under the MMA, due to the Part D low-income subsidy (LIS) and the risk-sharing arrangement. For example, one of the Minnesota plans said that the LIS and risk sharing covered half of its estimated \$260 per-member-per-month in pharmacy costs. Pre-MMA plans assumed full risk for pharmacy expenditures, whereas post-MMA Part D risk is limited to risk corridors. From this perspective MMA should theoretically have a favorable impact on the plans relative to pharmacy revenues.

Enrollment errors and revenue. A large concern in the first half of 2006 for all of the plans was the accuracy of the CMS Monthly Membership Report, which establishes the membership in and payment to the plans. Because of a variety of inaccuracies in CMS enrollment and disenrollment data (see the Marketing and Enrollment section below), health plans received estimated Medicare payments for the first part of 2006, without the necessary clarity to post revenues accurately. Although the membership glitches were largely resolved by the time we ended data collection (June 2006), the financial

⁵ Of course these plans are also affected by decisions related to the continuation of the frailty factor, but this is a demonstration-related decision, not a part of the MMA.

reconciliation was ongoing. One of the larger plans projected a revenue shortage of just over three million dollars.

The uncertainty about who was actually enrolled also had impacts on the expenditure side, since plans had to try to reconcile who should pay for services used by beneficiaries during months when their plan membership was listed erroneously (either in a PDP, the demonstration SNP, or no plan at all). Many plans said they were adding substantially to IBNR monthly in attempt to cover potential revenue shortfalls from the reconciliations. The financial reconciliation may negatively affect some health plans and may fail to elucidate the true pharmacy costs under early MMA implementation. In Massachusetts, where the enrollment glitches were most frequent, respondents feared that the reconciliation could be particularly damaging, as in some cases retrospective disenrollments were dated back to January 2006. Many of these presumed plan beneficiaries received services, including costly care coordination paid for by the health plan.

3. Medicaid Revenues

In recent years, Medicaid capitations to the demonstration plans in all states covered supplemental services typically offered by Medicare managed care plans (e.g., eyeglasses, preventive services), full pharmacy benefits, and a variety of in-home and institutional long-term care services. The MMA changed Medicaid's responsibility by taking over the bulk of the costs of prescription drugs, leaving Medicaid in the position of

supplementing with classes of drugs that were excluded in Part D. The most important of these were benzodiazepines, barbiturates, and over-the-counter medications.

Neither the state nor health plan respondents expressed much concern about the accuracy or adequacy of Medicaid payments for the supplemental drugs. States either used their own data and analysts (Minnesota & Wisconsin) or enlisted outside actuaries (Massachusetts) to first calculate the utilization and expenditures for the covered supplemental drugs and then add that to the sites' capitations. Because State Medicaid capitation rates were paid to the health plans as a composite rate, it was difficult for plans to judge whether total plan revenues for prescriptions drugs increased, decreased, or remained the same under MMA. Nevertheless, the sites said they were comfortable with the states' methodologies. Relative to the other financial changes they faced, this appeared to be a small matter, and also a matter that was in the "too early to tell" category.

States also faced the issue of whether and how to offset the \$1/\$2 and \$3/\$5 required Part D co-pays. The plans in the demonstration had been offering drugs without co-pays, and this feature was an incentive for beneficiaries to enroll. Along with the plans, states feared that the new Part D co-pays might impede access to needed drugs. CMS ruled early in 2005 that states could not use Medicaid funds (and federal financial participation) to pay for the Part D co-pays, but they could use 100% state funds to pay. Two of the states (Minnesota and Wisconsin) decided against the latter course, and the

co-pay requirement went forward. Massachusetts, however, legislated state funds to pay for the SCO co-pays, so sites received state revenue to cover these costs for beneficiaries.

C. Summary

The eleven comprehensive dual-eligible demonstration health plans made it through the bidding in 2005, into operations in 2006, and into the bidding in 2006 for 2007 relatively intact in terms of their benefits, their revenues, and their memberships (as will be seen in the next sections). But the process of moving from M+C/Medicaid financing to MMA/Medicaid financing took significant tolls on their administrators' attention and time, their administrative spending, and their comfort level in running integrated, comprehensive health and long-term care service systems.

The eleven comprehensive dual-eligible demonstration health plans made it through the bidding in 2005, into operations in 2006, and into the bidding in 2006 for 2007 relatively intact in terms of their benefits, their revenues, and their memberships.

Disintegration. A consistent theme that we heard from respondents in all states and virtually all health plans was the "disintegration" that MMA imposed on these fully integrated plans. These demonstration sites previously operated seamless integrated delivery systems, supported by a policy of "pooled revenues" in which Medicare and Medicaid did not look too closely at whether "their" money was supporting "their" services. This allowed the sites to reallocate resources to cross-over services - particularly in care coordination teams - intended to improve care and efficiency. In contrast, the MMA requires plans not only to closely track Medicare-type services and

administration, it also restricts the amount of savings (by 25%) and the use of savings (much goes to pay for uncovered prescription drugs). Aside from the 25% reduction in savings allocated to services, the impact of tracking who pays for what will have an impact only to the extent that CMS restricts what can be booked as Medicare administrative or service costs. So far, care coordination costs have been allowed as Medicare service and administrative costs "above the line" (i.e., before the 25% is deducted). Without this supportive policy these health plans would find it very difficult to maintain this key component for integrating their service systems.

Incentives. A specific manifestation of the disintegration tendency cited by respondents is a change in the incentive to invest in non-traditional services that may reduce the use of higher cost Medicare services, particularly hospital care. One administrator wondered why his plan should spend money on a home modification that Medicare will not recognize as allowable costs to save Medicare money. Medicare will take back 25% of any savings. Previous to MMA, this respondent said it made financial sense for a plan to pay \$5,000 on a service such as home modification that was specifically covered by neither Medicare or Medicaid to save \$10,000 on Medicare expenditure (such as a hip-fracture repair). Post-MMA, the incentive is mitigated by the 25 percent savings that is returned to CMS. Several respondents felt that under this system, plans will be less motivated to think and make decisions that support innovative and cost-effective care.

Misfit between MMA bidding and comprehensive plans. One of the Massachusetts plans described Part D bidding as "all risk and no reward." If they bid above the unknown Part

D benchmark, they would be required to collect a supplemental premium from their members that would likely make the plan unmarketable. But bidding low provided no market advantage, since their members would receive none of the lower premium dollars below the benchmark.

Cost-ineffectiveness. No plan was able to report any cost savings as a result of MMA. All of the new administrative costs were said to add no value for either the plan or the members. In fact, the time spent on collecting the data, tracking bidding instructions, reporting, complying, and communicating with members about the MMA, all distracted managers and even clinicians from doing their jobs to deliver better services to members. And members were not seen as better off either, given the confusion they faced with their new market choices, and the new costs they had to pay to get prescriptions that formerly were free. The only area of savings cited by some respondents was that their plan's prescription drug expenditures under MMA should be reduced as a result of plans moving from full risk for prescription drug costs to partial risk (shared risk with CMS) or no risk (100% low income subsidy). But such savings for the plan were small if any financial consolation in the face of the numerous perceived downsides to the MMA system. Since the plans saw little if any benefit from these extra systems and requirements, the term "cost-ineffective" sums up their views of these new burdens.

II. Marketing and Enrollment

A. Relevant MMA Provisions

The MMA established new rules and regulations that affect the general marketplace of providers serving the Medicare population. These rules not only allowed for new plan types to serve Medicare beneficiaries but also established new policies for how Medicare plans can market their products, new rules around beneficiary out-of-pocket costs, and new mechanisms for how Medicare beneficiaries can enroll in plans. More specifically, these changes include the following:

- The MMA established new and mandatory co-payments for the Part D prescription drug benefit. Although these are minimal for the dual-eligible beneficiaries, prior to this the 11 demonstration plans had a unique advantage in their marketplaces as plans offering no out-of-pocket costs for their enrollees. The MMA eliminated this niche and with it the potential for affecting each plan's ability to sustain membership and grow.
- The MMA introduced a bidding process, which could further affect beneficiary out-of-pocket costs by producing a premium. Although demonstration health plans intended to achieve premiums equal to the low-income subsidy and thus protect their members from any out-of-pocket premium costs, the \$5 monthly premium for members at one of the Wisconsin plans in 2006 showed that there was no guarantee of this. Prior to MMA the premium policy was more flexible, and in many cases could be rolled into what states paid for under cost sharing.
- The MMA created several new provider types to serve Medicare beneficiaries, including general MA-PDs (Medicare Advantage plan with a Part D benefit), as well

as stand-alone Prescription Drug Plans (PDPs). Also dual-eligible beneficiaries can be served in Medicaid SNPs.

- The MMA also offered several new enrollment mechanisms for beneficiaries. Some of these mechanisms were for beneficiaries to help them make plan choices; other mechanisms were for health plans to help them retain membership; and others still were intended to ensure that no low-income beneficiary would be without the new Part D drug coverage. For beneficiaries, the MMA allowed dual-eligible beneficiaries to electively change plans every thirty days, unlike the general Medicare population, which is "locked in" to the plan they choose by calendar year. For health plans, the most important retention mechanism was that plans were allowed to passively enroll beneficiaries enrolled in existing Medicaid-only plans into new companion MA SNPs, as well as to roll-over existing MA SNP members into the new SNP with Part D. Prior to passive enrollment or roll-over, the beneficiaries were given the opportunity to opt out. Finally, to ensure that no beneficiary was without drug coverage, beneficiaries who did not select a drug plan by December 31, 2005, were auto-enrolled into a PDP by Medicare on January 1, 2006. CMS randomly assigned non-enrolled dual-eligible beneficiaries to a PDP in their region with premiums at or below regional average. Managing this process and the confusion that came along with it was another change introduced by the MMA.
- Lastly, the MMA introduced new marketing requirements that affected how plans could interact with prospective and existing enrollees, including the requirement to operate a customer service call center. Also, all marketing and beneficiary communications and provider communications required CMS approval. For some

plans, this introduced a new level of paperwork not experienced before the MMA, and for others it was a continuation of what they had done before but with some new twists.

We queried representatives of each plan regarding three primary topics within the area of marketing and member enrollment: (1) marketing strategies and growth, (2) new administrative procedures necessitated by the MMA, and (3) the experience of plan members through the transition. In order to understand the sites' success in holding on to members at the transition into MMA in January, 2006, and their success in initial growth under the MMA, we also asked plans for enrollment data for the last month in 2005 and the first six months of 2006. We report our findings below in terms of how these changes affected the plans themselves, followed by how these changes affected the plans' members.

B. The Impact of MMA Marketing and Enrollment Provisions on Health Plans

All 11 plans and the State Medicaid administrators conveyed concern that many of the CMS guidelines and directives were not sensitive to the reality of smaller plans and the needs of the fully integrated demonstration projects. Nevertheless, all the demonstration plans generally maintained old members and added new ones. In this section we discuss how plans achieved this success and what new processes and resources they devoted to the transition as a result. In particular, we address the following:

- Competition
- Retention strategies
- Growth strategies

- Co-payments and premiums
- Other administrative demands, including compliance with new marketing material requirements and managing member confusion.

1. Competition

Prior to MMA, the 11 demonstration sites reported relatively little competition from other Medicare products. Most experienced their niche in the market as unique, serving a frail population that few providers were interested or experienced in serving. Of the competition they did report, it was more often from other demonstration plans (in the case of Minnesota and Massachusetts).

All of the health plans, with the exception of the Minnesota plans, indicated that the first year of MMA did not produce new competition for them. A few traditional HMOs entered the market as SNPs, but they did not offer the fully integrated product of the demonstration plans and as such were not perceived as being in direct competition. All plans expected much more competition in 2007 with a greater number of SNPs entering their respective market places serving beneficiaries that are dual-eligible or have chronic conditions. All the plans reported the emergence of many PDPs within their service areas. However, none of the demonstration plans viewed PDPs as competition. Rather, they regarded them in the words of one respondent as more of a “nuisance than real competition.”

None of the demonstration plans viewed PDPs as competition. Rather, they regarded them in the words of one respondent as more of a “nuisance than real competition.”

In Minnesota, increased competition was largely the result of the state-wide expansion of MSHO product (discussed below in section 3 under growth strategies). One health plan reported that the competition stemmed from the differences in provider/service delivery systems rather than health plans per se, although the same plan reported that three new health plans entered its service market. One new Medicare fee-for-service plan attracted low-income dual-eligible beneficiaries with a zero premium product. It was advertised to be equivalent to MSHO, but its services were not integrated and comprehensive. Members who left a MSHO plan for this particular health plan were reported to have returned to MSHO once they experienced this differential care.

2. Retention Strategies

We explored the degree to which the various MMA enrollment mechanisms affected the 11 demonstration sites in terms of their ability to retain their existing member base. We found that all 11 demonstration plans used the roll-over enrollment option. The Minnesota plans also used the passive enrollment option for beneficiaries in their Medicaid HMOs. Both proved to be relatively good - though not perfect - tools for retaining members.

In the fall of 2005 leading up to the implementation of the MMA, the burden was placed on the health plans to make sure that their members understood the necessary decisions that needed to be made and how members would be affected by their choices. For all of the plans, the member care teams played an instrumental role in ensuring that members

understood the plan benefits and the directive to phone Member Services if questions arose. The intent with all plan activities was to ensure that members understood they had Part D benefits as part of their integrated comprehensive benefits and did not need to take any further action. The plans in Wisconsin and Minnesota mailed letters proactively to members in the fall, while the Massachusetts plans depended solely on telephonic outreach due to the poor health literacy skills of their members.

Across the 11 plans, estimates of how many members were successfully retained using roll-over ranged from 60% to 95% of their December 2005 members. The 60% figure was reported by a Massachusetts plan that had enrolled many new members in the fall of 2005, and these members were not recognized on the CMS system. Other plans were much closer to the 95% retention than the 60%. Among the members who were not retained through roll-over, sites reported the following scenarios:

- Plan members mistakenly signed up for a PDP in response to the mailings they received from PDPs in the area. These members did not realize that by doing so they would be automatically disenrolled from their current health plan.
- Members were mistakenly auto-enrolled by CMS into a PDP, and again concurrently disenrolled from their demonstration plan.
- A few members who were enrolled in a demonstration plan through employer coverage were switched to the employer's plan when it converted to a MA plan. MMA does not allow a beneficiary to be enrolled in two MA plans, and employer plans take precedent over other types of MA plans.

- Still other members, though a relatively small number of them, voluntarily opted to disenroll from the demonstration plans following the MMA implementation.

Managing the errors, which involved working with CMS and others, and re-enrolling members who were mistakenly dropped from the health plan membership rolls, took considerable staff time and resources over several months at the plans, states, and CMS. One plan in Minnesota reported ongoing back-and-forth with CMS to correct enrollment.

As many as 1,000 beneficiaries in this plan were affected by a variety of enrollment problems. Many of the beneficiaries were on CMS eligibility tapes but had decided to opt out of MSHO. State and health plan personnel were required to make changes

It took long hours to address the enrollment errors while other work priorities were neglected.

manually. It took long hours to address the enrollment errors while other work priorities were neglected.

One Massachusetts plan reported that while the enrollment was correct by the early summer, the financial reconciliation would be a “nightmare.” The IBNR (incurred but not reported) costs were unknown during this “blurry” period, since members accessed services without being clearly identified correctly within the CMS system. One plan reported paying for medical services and prescription drug benefits for a beneficiary for several months before the plan received information from CMS that the beneficiary had been retrospectively disenrolled back to January. Plans spent many hours working with CMS to ensure that plan records of membership month to month were accurate for the purposes of appropriate provision of services to beneficiaries and to ensure that plans

were paid appropriately. Additionally, once CMS enrollment windows were finalized, Medicaid enrollment and payment for months uncovered by Medicare had to be reconciled.

By May 2006, when we completed our interviews, some sites were still dealing with these issues, though most of the problems had been cleared up. However, because dual-eligible beneficiaries have the special status of being able to change plans every 30 days, sites feared that changes in enrollment (either deliberate or mistaken) might continue to be an ongoing challenge.

Although straightening out the enrollment and payment situation was a major inconvenience and frustration for federal, state, and health plan staff, it is important to point out that informants said that there was little if any disruption for beneficiaries enrolled in these plans. All involved worked to shield beneficiaries from the confusion and to maintain continuity in their services and benefits.

Federal, state, and health plan staff worked to shield beneficiaries from the confusion of enrollment and disenrollment errors and to maintain continuity in their services and benefits.

3. Growth Strategies

In addition to retaining existing members, we explored with plans their intention around the membership strategies they proposed. In particular, we were interested to learn if changes in the marketplace due to MMA were resulting in new marketing strategies among the study plans.

We found that all demonstration plans except one plan in Wisconsin intended to grow their dual-eligible membership. The one plan in Wisconsin – the smallest plan in our study with less than 350 members – planned to expand the Medicaid side of its business via new markets and products, but was actually considering getting "out of the Medicare business altogether" due to the new administrative demands of MMA.

Among the 10 plans with a goal to grow their dual-eligible beneficiaries' membership, the situations differed rather significantly by state. In Minnesota, MSHO went statewide in 2006, and the number of MSHO plans tripled. In Massachusetts, the plans were all still relatively new and still in an expansion mode. In Wisconsin, the plans were more established and stable, yet most still had growth plans. Despite these differences, none talked about the need to alter their pre-existing marketing strategies because of MMA, at least not in 2006. Several anticipated more SNPs entering their markets in 2007, which in turn may demand new strategies.

For now the main approaches to growing membership for all plans was by expanding service areas into additional counties and/or by contracting with additional medical groups. As employed prior to MMA, new community providers were identified in accordance with prospective beneficiary needs and added to the contracted networks. As a requirement of service expansion into new areas, new provider networks were formed. One plan in Massachusetts commented that growing competition increased the physician payment rates required to secure contracts in new service areas. This same plan

anticipated that physician contract rates would continue to rise with the projected increase in the number of dual-eligible SNPs and chronic care SNPs scheduled to enter the market in 2007. There were unique approaches in the different states.

Minnesota - statewide expansion: Minnesota experienced the greatest change with respect to member growth, due to a state decision in 2004 to try to greatly expand MSHO in 2005 and 2006. The expansion (approved by CMS in December 2004) added six new health plans to MSHO and extended the program from the Twin Cities region across the entire state. The six new health plans had all been serving dual-eligible beneficiaries through Medicaid HMOs (Prepaid Medical Assistance Plans or PMAP) without companion Medicare HMOs. The three MSHO sponsors also had PMAP plans, which served dual-eligible beneficiaries who wanted to be in the sponsor's health plan but not in its MSHO option. Like the MSHO plans, the other PMAP sponsors all formed MA-SNPs in order to take advantage of the passive enrollment option for their PMAP members. In short, the state, the health plans, and CMS used the passive enrollment option under the MMA implementation to allow MSHO to go statewide and to move large proportions of PMAP members to MSHO in a single stroke.

In the statewide expansion, most plans focused their marketing on their own PMAP members. Additionally, the options for MSHO plans were presented by county Medicaid eligibility staff, who distributed materials supplied by the plans offering coverage in that county. The MSHO plans worked closely with county Medicaid workers to accurately convey the benefits and providers covered under these plans. Minnesota respondents

emphasized the importance of county workers' understanding the benefits of enrollment in MSHO. The county workers provided health plan marketing material listing the primary care physician network and were not permitted to make recommendations. Dual-eligible beneficiaries could still choose PMAP and not join MSHO, but this was not a common choice. If the beneficiary failed to make a choice, the state randomly assigned them to a PMAP plan by ZIP code. If the beneficiary did not like the assignment, s/he could go back to the county and change.

Although MnDHO-PD was not affected by the statewide expansion or the increase in managed care competitors that the MSHO plans faced, it was still affected by the confusion and enrollment/disenrollment errors that accompanied the introduction of Part D. Nevertheless, MnDHO-PD continued its steady increase in members.

Massachusetts - Community-Based Marketing: All three Massachusetts plans reported continued service expansion through existing community-based marketing approaches. The plans reached out to non-English speaking communities as a key growth strategy. Health plans hired individuals from the community to work in local offices to facilitate communication, transportation, and physician information for members and interested beneficiaries. The plans found that overcoming language barriers through bilingual employees and translated materials was critical to this approach. Two of the plans partnered with community health centers as a key strategy in penetrating new communities and building trust and relationships within the communities they intend to serve.

Additionally, Mass Health (State Medicaid) hired a public relations company and utilized a mobile SCO van to canvass communities and “get the word out” about the benefits of SCOs. The "SCO-Mobile" traveled throughout the state in areas of greatest need and offered blood pressure screenings, other health checks, care manager health information, and spokespersons’ encouragement. The SCOs worked with the state to identify key areas to target based upon their respectively identified health networks and the potential for further growth. All SCO health plans were invited to participate in all scheduled events. Also, Mass Health worked with the housing authorities to gain entrance to senior housing developments to promote SCOs. This was in response to the health plans' difficulties gaining entry into these developments due to the housing authorities' strict access rules aimed at protecting vulnerable seniors from fraud and abuse scams.

The Massachusetts plans expressed concern over the sunset of the provision for service to defined populations that was afforded the demonstration plans. The Massachusetts plans were not serving the disabled population (Medicare and Medicaid beneficiaries under 65 years of age). The SCO demonstration status was used to establish an integrated care delivery model focused on geriatric care with the goal of delaying entrance to nursing home for dual-eligible seniors. The Massachusetts plans expressed a desire for CMS to reexamine its requirement to open up enrollment to beneficiaries of all age for the plans after the current agreement expires at the end of 2008.⁶

⁶ CMS met these concerns by permitting "subset" plans in 2008 applications, for which all demonstration plans are expected to qualify, along with other potential health plan applications with appropriate state buy-in.

Wisconsin - Expanded Territory: Three of the four Wisconsin demonstration plans intended to expand by extending services into additional counties. However, growth was limited for these plans by the requirement that all enrollees be nursing home certifiable. Wisconsin plans were further challenged because expansion applications were due nine months prior to the intended date for the initiation of services in the new service areas and were required to include fully executed provider contracts. Additionally, the MMA exacerbated an existing problem in Wisconsin relative to establishing contracts with Critical Access Hospitals serving rural areas. One of the Wisconsin demonstration plans served a primarily rural population, and most rural hospitals are Critical Access. These hospitals were said to believe that in order to maintain their cost reimbursement structure they could not contract with Medicare managed care plans. The Wisconsin demonstration plans had previously avoided this problem, since their waivers had exempted them from becoming Medicare+Choice plans. This aspect of their waiver coverage ended when they became SNPs.

In summary, beyond the use of roll-over and passive enrollment, the health plans in all three states reported they did not use any new marketing approaches as a result of MMA. They continued to follow the marketing approaches that were successful prior to MMA, such as “word of mouth” through medical groups and medical group office staff, nursing facilities, family members, etc. Medical groups remained the most significant referral source for all plans except the Minnesota plans. A key part of marketing for all plans was their promotion of the benefits of the integrated care model. Marketing efforts were

targeted at key individuals within the community, such as Area Agency on Aging staff, personnel working for senior housing units, and county workers (in the cases of Minnesota and Wisconsin plans) to ensure awareness of the unique benefits offered by these fully integrated health plans. Additionally, states and counties made significant efforts in outreach, education, and health benefits information assistance. These efforts contributed greatly to making the transition to MMA as seamless as possible under difficult circumstances.

4. Co-Payments and Premiums

As described previously, 10 of the 11 demonstration health plans allocated enough rebate funds to ensure that there was no monthly premium for members. The SCOs were able to offer Part D benefits without standard co-pays due to Massachusetts State legislation passed late in 2005 that allocated state general revenue funds to pay for SCO members' co-pays. As the Part D medication benefit was a strong component of the SCO marketing approach, and these plans utilized integrated marketing materials, this legislation was seen as a tremendous benefit to SCOs. In Wisconsin and Minnesota, plans introduced the co-payments to new members, and with the exception of one plan in Wisconsin, did not report losing membership as a result. The one Wisconsin plan that lost membership operated a PACE site along side its Partnership product. PACE programs do not have Part D co-payments under the MMA. This Wisconsin plan reported that the co-payment under MMA caused some Partnership members to switch over to PACE to avoid the co-

payment. This plan also reported that new members were more likely to select their PACE product over Partnership, because of the co-payment difference.

Although drug co-pays appeared to result in little if any membership loss, another concern over co-payments expressed by these plans was the effect co-payments might have on drug utilization. Medication adherence was challenging to achieve with this population, and plans conveyed concern that the co-payment would further exacerbate this problem, resulting in members' not taking the drugs they should. The amounts - \$1 per prescription for generics and \$3 for brands - seemed small, but they could be significant for individuals living on very low incomes (the individual SSI rate in 2006 in Wisconsin, for example, was \$687 a month) and taking 10 to 15 prescriptions a month (the averages across WPP plans).

One plan in Wisconsin marketed the MA-SNP product with a \$5 premium. This plan intended to evaluate its merit and had not experienced any loss of membership as a result of the premium at the time of our interviews. While no member had failed to pay the premium, this plan did not intend to disenroll any member for failure to pay the premium.

5. Administrative Changes

The MMA introduced numerous new CMS administrative structures and policies, which were reflected in new demands for these new SNPs. Changes included new guidelines and oversight concerning how plans marketed their services and communicated with

beneficiaries about the transition to MMA, dual state and federal review of marketing materials, a new CMS website, and requirements for extended hours for marketing information phone lines.

Content and review of marketing materials. The MMA prescribed a range of information materials that all plans had to provide to current and prospective members, including the Evidence of Benefits (EOB), the formulary, information on potential changes in contracted network, a comprehensive listing of the network, information on grievances and appeals, and a description of the quality assurance program, including the medication therapy management program.

Consistent with previous Medicare and Medicaid requirements, all written communications with members had to be approved by the CMS Regional Offices prior to use. CMS distributed model language for inclusion in member communications to assist plans with the transition of MMA. If model language was used exclusively within the materials, the plan could submit to CMS for approval under the “file and use” certification. This meant the plan could use the submitted materials within five days of CMS submission. If plans altered the CMS model language, the review process could extend to 45 days. Additionally, all communication with enrollees must be sent via the US mail and be posted on the plan’s website at the time of enrollment and annually.

For materials describing services for dual-eligible beneficiaries, State Medicaid review and approval processes also applied. Except for the Wisconsin plans, which had not been

licensed previously as Medicare managed care plans (but now are), dual Medicare and Medicaid review was not a new requirement. Although the task of getting dual review and approval was described as arduous, all the health plans said they were successful in creating and distributing integrated marketing materials that described both Medicare and Medicaid benefits.

In Wisconsin, the four WPP plans collaborated to develop a common baseline of integrated marketing materials. Documents were first reviewed and approved by the Wisconsin Department of Health and Family Services, and then forwarded to the CMS regional office for review and approval. The CMS regional office assigned a single individual to review and approve the WPP plans' materials, and the plans were extremely complimentary of the responsiveness of CMS to their unique needs. The resulting products included an integrated Summary of Benefits that reflected both Medicare and Medicaid benefits in one document, and an integrated, 150-page Evidence of Coverage that provides detailed descriptions of the benefits and how the plan works.

In Minnesota, one of the plans reported that the development of marketing materials was challenged by the different requirements of Medicaid and Medicare. Minnesota Medicaid required a 7th grade reading level, yet CMS required model language. Health plans had to modify their text to comply with the state, and then Minnesota State Medicaid worked with the regional office to negotiate the discrepancy.

In Massachusetts, the SCOs submitted all integrated plan materials to Mass Health first and then to CMS for approval. One Massachusetts health plan cited a disconnect between their regional CMS office and the central CMS office that delayed the approval of member materials.

Despite these challenges, in all states most plans expressed gratitude to CMS for their responsiveness and recognized that given the enormity of the MMA implementation process, the undertaking went fairly smoothly.

Mis-fit of comprehensive SNPs and CMS website. There was a sense among respondents that their comprehensive dual-eligible plans did not fit well into the CMS marketing and communications structure for MA plans. One plan summarized the issue as follows: “Integrated plans appear to be responded to with ‘work-a rounds’ relative to the implementation of MMA. There are currently no operations in place that speak directly to the integrated plans.” As an example, one plan cited the CMS website for consumers (www.medicare.gov) that failed to accurately reflect the full scope of benefits offered by the integrated plans. It also listed premiums and deductibles that did not exist for the dual-eligible members.

All states and most plans expressed gratitude to CMS for their responsiveness in reviewing marketing material and recognized that, given the enormity of the MMA implementation process, the undertaking went fairly smoothly.

When the www.Medicare.gov site was accessed in April 2007, the inaccurate information about the dual-eligible plans was no longer there, but this was remedied by providing

almost no information at all. The website screens in Appendix 1 show what beneficiaries would have seen as they moved through the site. After picking a state and county (Suffolk in Massachusetts, i.e., Boston was used here), the first screen showed that users could choose from 51 PDPs, 14 regular MA plans, and 10 SNPs. If they chose to look at MA plans, the next screen showed they saw total monthly premiums, drug premiums, drug deductibles, and coverage in the gap for each plan. If they chose to look at SNPs, the next screen showed that they saw none of this information but rather are told only that these plans were for dual-eligible beneficiaries. If they went on to look at a particular SNP (e.g., Senior Care Options), the next screen showed that, rather than being told something about the extensive benefits and low or zero premiums of the plan, they were told that premium and deductible information were "not available." When the "View important notes and benefit summary" box was clicked, the next screen just repeated that no information was available and recommended contacting the plan. When users went back and clicked the link to the plan, they were taken to a page on which "leaving the www.Medicare.gov" message stood out, i.e., they were not yet linked to the plan. If they looked down a little, the link to Commonwealthcare.org was there and active, and it brought the user to the plan. In the case of Senior Care Options, the user was taken to the pharmacy benefit screen of the Senior Care Options program of the Commonwealth Care Alliance website. To get to the comprehensive benefits of the demonstration-based SNP, the user needed to scroll up to "benefits" of Senior Care Options. It's worth noting that this small plan was offering two SNPs - Senior Care Options (with the comprehensive Medicaid benefits) and Commonwealth Care Connection (without Medicaid benefits), so there was room for confusion even on the corporate website. In the case of SNPs offered

by larger health plans that had multiple products, e.g., Medica in Minnesota, the user had to find the SNP among the many Medica products on the site. The CMS link took users to the Medica home page, where they needed to select "products," then "Medicare products" on the next page, then "Medica DUAL solutions" on the next page (the MSHO plan). In summary, the www.Medicare.gov website did nothing to describe, compare, or promote the special benefits and low costs of comprehensive SNPs for dual-eligible beneficiaries; and even some of the health plans sponsoring the products developed through the demonstration present a less than straightforward pathway to their SNP options with the most comprehensive benefits.

Call center requirements. Finally, CMS introduced a new requirement that plans have staff available by phone from 8 AM to 8 PM, seven days a week to ensure that consumers can obtain information related to Part D. As these integrated plans already committed considerable resources to member outreach,

The www.Medicare.gov website did nothing to describe, compare, or promote the special benefits and low costs of comprehensive SNPs for dual-eligible beneficiaries,

education, and communication across service teams, and since their members were closely hooked to clinical care teams for information, the smaller plans, particularly, believed this was an unnecessary requirement. Plans argued that their members called their clinicians with all questions - not customer service reps. Several plans reported that the only calls they received on the call center lines were from the HHS "mystery shopper" contractor. A respondent at a Minnesota plan explained how the plan tried to use its clinical contact system to respond to the mystery shoppers but was deemed non-compliant: For example, a mystery shopper would call and say they wanted to talk about

"Uncle Bob," so since it was a family, the plan gave the case manager's number. If the caller got the case manager's voice mail, it was a "no contact" and non-compliant. In response, this plan "beefed up" its call center. Their first try was to use their nurse triage line to cover the calls from 6PM to 8PM and on weekends. The nurse's job was to triage the calls, and the mystery shopper calls were less important than clinical calls, so the shoppers were sometimes getting put on hold for extended periods, which again was deemed non-responsive. So the plan was forced to add time to their regular customer service staffing: two hours weekdays (6-8) and two 8-8 shifts on weekends to meet the CMS requirements (28 hours a week or 0.7 of a full-time-equivalent).

C. The Impact of MMA on Plan Members

As detailed above, demonstration plans went to great lengths to ease their members through the transition. Despite best efforts, however, all the health plans reported that some of their members experienced enrollment problems – either the member was auto-enrolled in a PDP when they should not have been, were retained as plan members when they had elected to enroll elsewhere, or were not retained as a plan member even though they did not opt out of passive enrollment. In this section, we discuss these and related ways plan members were affected by MMA and how plans responded. It is important to reiterate that these member impacts are those reported by the plans, not by beneficiaries. We did not interview beneficiaries for this report. We review the reported impacts in two areas:

- Member options, choices and experiences: What was presented to members, how did they choose, and how did their choices turn out?

- Enrollment data: What were the actual enrollment levels at each of the plans for 6 months following MMA implementation?

1. Member Options, Choices, and Experiences

The implementation of MMA contained many opportunities for members of the demonstration plans to be confused. Although these members did not have to do anything in order to maintain the coverage they had prior to MMA, they were nonetheless exposed to a number of mailings and directives from CMS, from their own plans, from the states, and from new PDPs that were actively reaching out for new enrollees. In the fall of 2005, all MA SNPs were required to notify their dual-eligible members by mail of the roll-over and passive enrollment options, giving members until October 30 to opt out of their current health plan. Concurrent with these mailings, members were also receiving marketing and informational materials from other sources (particularly stand-alone PDPs), as well as public service announcements advising them to act or face adverse consequences. Plans reported that CMS-approved language lacked specific clarity applicable for dual-eligible beneficiaries. If members interacted with retail pharmacies, they became more confused as pharmacy personnel also tried to provide the “CMS approved language regarding choice, timelines, etc.” The letters received from the federal government were said to be perceived by some members as directives to enroll in a PDP despite what they were told by their respective health plans. In sum, the amount of information flowing during the implementation period would be a challenge for even

the most competent, and was potentially that much more daunting for a poor, elderly, and often frail and disabled population.

Despite the potential for problems, most of plans reported that their members made it through the transition with minimal confusion and stress. This was largely true because each of the demonstration plans devoted considerable staffing and resources to working with members around the transition. Plans reported training their staff about MMA and how to assist and field questions from beneficiaries. Plans also set up systems to proactively educate members about MMA and its implications for individual beneficiaries. Plan size seemed to affect the level of confusion felt among plan members. Smaller plans, like those on Wisconsin, were able to provide personal assistance to individual members, and this appeared to help members to make the transition fairly insulated from the sea-change in the market. In contrast, the larger Minnesota plans, while also devoting enormous staff resources to the transition, spoke about more wide-spread confusion among beneficiaries.

Two exceptions to the decision to stay were reported by the plans. One was a plan in Minnesota that reported some members opted out of passive enrollment because of the requirement to have a care coordinator. Some beneficiaries chose to stay in Prepaid Medicaid Assistance Program (PMAP) because they were said not to want a care coordinator and did not want the "hassle" of making a change. Another exception, as reported previously, was that some members of one of the health plans in Wisconsin switched to the sponsor's PACE program, reportedly to avoid Part D co-pays.

In spite of the general decision to stay, there were instances reported in which beneficiaries did not end up in the plan of their preference. First, all but one plan reported that a few members did enroll in a Part D plan by mistake due to receipt of conflicting messages and thinking that the “government” had sent them a directive to sign up. Two plans reported that a few members used prescription drug cards that were mailed unsolicited to members; members became disenrolled from integrated plans and enrolled in PDPs once the prescription drugs cards were used at the pharmacies in January 2006 to fill a prescription. Respondents reported that virtually all beneficiaries who inadvertently signed up for PDPs returned to the health plans once they understood the ramifications of their choice, although the Wisconsin health plans expressed that it was difficult to get members out of stand-alone PDPs if they mistakenly enrolled.

A second way that true beneficiary preferences were not followed resulted from CMS error rather than beneficiary confusion or aggressive PDP marketing. Even when the plans were successful at communicating that members could stay in their health plan if they did nothing, and members did nothing, some were mistakenly auto-enrolled by CMS into a PDP. The source of this mistake seems to have been the fact that CMS did not recognize members who joined a demonstration plan in October to December 2005 (in Wisconsin, plans reported that enrollment after August 2005 was not recognized by CMS). The larger the plan, the larger the pool of members likely to be affected.

Some plan members were mistakenly auto-enrolled by CMS into a PDP. The source of this mistake seems to have been the fact that CMS did not recognize members who joined a demonstration plan in October to December 2005.

Members caught by this administrative error often learned they were in a PDP only when they went to fill a prescription and were told they were no longer in the plan they thought they were, or were charged the wrong co-payment amount. In a few cases the inverse happened: Beneficiaries who had opted out of the passive enrollment choice were notified of enrollment in the integrated health plan when they were not actually plan members any longer. The plans maintained coverage for their members while enrollment errors were sorted out. In some cases, services were provided to beneficiaries that CMS did not have enrolled as members, and the health plan was not paid for them. In other cases, beneficiaries were enrolled correctly in the integrated health plan, but the plan did not have the member in their systems. All the plans reported that they were eventually able to resolve all enrollment errors made in the passive enrollment process.

Finally, with the exception of the one health plan in Wisconsin described above, members enrolled in these fully integrated plans were seldom disenrolling voluntarily after January 2006, despite the ability to do so (dual-eligible members had the right to change plans every thirty days). This is an important "non-finding" from our interviews.

2. Enrollment Data

To support the evaluation we asked all plans to report their monthly enrollment from December 2005-June 2006. We were interested in the number of new members coming to each plan each month, as well as the number of members leaving each plan each month. We also asked plans to tell us, if they could, why members disenrolled. The intent of

collecting these data was to get a sense of changes in plan enrollment from the last month pre-MMA, and then during the first six months of MMA implementation. While observed trends cannot be ascribed to MMA per se, when coupled with what we learned on our qualitative interviews, they provide yet another data point to understand what plans and beneficiaries experienced during the start of MMA.

Table 3 shows the memberships for the 11 demonstration plans for the first six months of 2006. Each enrollment month column begins with the membership total from the previous month, then denotes the number of new members during that month, the number of members disenrolled during the month, and the net census for that respective month. For example, Wisconsin Partnership Plan A had 309 members in December 2005, and three members joined and none quit in January 2006, leading to 312 members for January 2006. These figures reflect the corrected membership after resolving enrollment mistakes. The last two columns show the net growth rate for the plan from December 2005 to January 2006, and then for the six months from January through June 2006.

Table 3: Enrollment, Disenrollment, and Growth - 12/05-6/06

Wisconsin Partnership Plans		Jan	Feb	March	April	May	June	% Growth (Dec 05 to Jan 06) % Growth (Jan 06 to June 06)	
Community Living Alliance	Previous month	309	312	315	311	312	320		
	New	3	5	0	5	11	8	1%	4%
	Disenrolled	0	2	4	4	3	5		
	Net Census	312	315	311	312	320	323		
Eldercare of Wisconsin	Previous month	525	531	534	543	554	568		
	New	13	11	12	16	19	16	1%	9%
	Disenrolled	7	8	3	5	5	7		
	Net Census	531	534	543	554	568	577		
Community Care for the Elderly	Previous month	301	291	287	286	279	266		
	New	3	2	5	3	4	6	-3%	-8%
	Disenrolled	13	6	6	10	17	3		
	Net Census	291	287	286	279	266	269		
Community Health Partnership - elders	Previous month	524	530	534	543	558	586		
	New	11	14	14	23	35	28	1%	14%
	Disenrolled	5	10	5	8	7	8		
	Net Census	530	534	543	558	586	606		
Community Health Partnership - disabled	Previous month	245	257	254	262	269	281		
	New	14	2	9	9	16	20	5%	16%
	Disenrolled	2	5	1	2	4	2		
	Net Census	257	254	262	269	281	299		
WPP Total	Previous month	769	787	788	805	827	867		
	New	25	16	23	32	51	48	2%	15%
	Disenrolled	7	15	6	10	11	10		
	Net Census	787	788	805	827	867	905		
Minnesota Senior Health Options Plans									
UCare	Previous month	4198	7294	7496	7644	7652	7639		
	New enrollees	3276	383	300	242	216	235	74%	6%
	Disenrolled	180	181	152	234	229	175	*	
	Net Census	7294	7496	7644	7652	7639	7699		
Medica	Previous month	3,206	9,533	9,456	9,530	9,658	9,632		
	New enrollees	6,535	406	374	442	193	210	197%	0%
	Disenrollees	208	483	300	314	219	331	*	
	Total enrollees	9,533	9,456	9,530	9,658	9,632	9,511		
Metropolitan Health Plan	Previous month	381	1005	1002	990	994	982		
	New enrollees	634	10	3	18	7	14	164%	-3%
	Disenrollees	10	13	15	14	19	23	*	
	Total enrollees	1005	1002	990	994	982	973		
MSHO - TOTAL	Previous month	7,785	17,832	17,954	18,164	18,304	18,253		
	New enrollees	10,445	799	677	702	416	459	129%	2%
	Disenrolled	398	677	467	562	467	529	*	
	Net Census	17,832	17,954	18,164	18,304	18,253	18,183		
Minnesota Disability Health Options-PD									
UCare	Previous month	537	568	594	614	640	659		
	New enrollees	41	35	27	37	32	28	6%	18%
	Disenrollees	10	9	7	11	13	15		
	Total enrollees	568	594	614	640	659	672		
Massachusetts Senior Care Options Plans									
Commonwealth Care									
Alliance	Previous month	520	554	581	620	655	702		
	New	40	33	45	39	53	73	7%	39%
	Disenrolled	6	6	6	4	6	5		
	Net Census	554	581	620	655	702	770		
Senior Whole Health	Previous month	1,375	1,509	1,645	1,795	1,970	2,102		
	New	146	147	166	189	155	140	10%	47%
	Disenrolled	12	11	16	14	23	22		
	Net Census	1,509	1,645	1,795	1,970	2,102	2,220		
Evercare	Previous month	1214	1415	1496	1571	1633	1722		
	New enrollees	215	103	88	90	107	144	17%	30%
	Disenrollees	14	22	13	28	18	23		
	Total enrollees	1415	1496	1571	1633	1722	1843		
SCO - TOTAL	Previous month	3,109	3,478	3,722	3,986	4,258	4,526		
	New	401	283	299	318	315	357	12%	39%
	Disenrolled	32	39	35	46	47	50		
	Net Census	3,478	3,722	3,986	4,258	4,526	4,833		

*Large increase in January represents one-time passive enrollment of PMAP enrollees.

The table shows that all but one health plan both held onto their members as they transitioned into the MMA in January, and also grew in membership in the first six months of the MMA in 2006. However, there was wide variance among the states and individual plans.

The Wisconsin Partnership Plans experienced the least growth. As noted earlier, the WPP plans were well established and served the most frail, medically complex patients with a requirement of NHC status for plan enrollment. This population has a built-in high turnover due to high rates of death, which has been the cause of the bulk of disenrollments in these plans over the years. Three of the four plans continued to add small numbers of members in January, but one - Community Care for the Elderly - lost members, mostly to its PACE site. Collectively the four WPP plans (with five products) grew 15% from December 2005 to June 2006.

The Minnesota Senior Health Option Plans enjoyed the greatest growth as a result of the state-wide expansion of the MSHO option and the opportunity for passive enrollment as discussed previously. Virtually all of the growth in these plans occurred in January, when passive enrollment took effect, and they moved most of their PMAP members into their MSHO options.⁷ Additionally, the bulk of their MSHO members were rolled over. Overall, these three plans more than doubled their MSHO memberships to start the year.

⁷ When the six additional health plans are included, MSHO enrollment jumped from 6,000 to 33,000 with the aid of passive enrollment.

In the rest of the year growth was almost flat. These plans also reported large numbers of disenrollees over the six month period. The impact of this state-wide expansion should be followed by health plans and policy makers to determine if disenrolled members subsequently enrolled with competing MSHO plans, Prepaid Medicaid Assistance Plans, or Medicare PDPs. Finally, the small MnDHO-PD plan continued to grow, both in the December-January transition and through the first six months.

All three of the Senior Care Option plans in Massachusetts grew strongly, both in the December-January transition (mean of 12%) and in the next six months (mean of 39%). The Massachusetts plans provided some information about the reasons members joined or left a particular health plan. The majority of new enrollees resulted from referrals within provider groups. The SCOs also received referrals from Mass Health, but provider groups outnumbered these referrals by twenty to one. Despite the SCO requirement to contract with ASAPs (Aging Services Access Points - the local Area Agencies for Aging), referrals to the health plans were not increasing from this source as anticipated. The primary reason for member disenrollment was death rather than voluntary disenrollment. For those members who did voluntarily disenroll, the primary reasons reported by the plans were (1) that beneficiaries changed their doctor, and (2) loss of Mass Health benefits. At least in Massachusetts, it appears that most members who joined an integrated plan tended to stay in the plan over time. For the most part, dual-eligible beneficiaries did not seem to be exercising their option to change plans every thirty days.

Some of the plans were also able to report changes in the type of member served. When the Minnesota plans passively enrolled large numbers of PMAP enrollees, it changed their case mixes to look more like the state dual-eligible Medicaid population. Two of the plans in Massachusetts and Minnesota had a reduction in the percentage of enrollees who were NHC. One Massachusetts plan reported an increase in nursing home enrollees, but this was thought to be simply the result of members' aging. One plan experienced an influx of younger enrollees, increasing the percentage of enrollees who were Medicare Disabled to 20%. The Massachusetts plans increased their members with language preferences other than English and attributed this change to their community-focused marketing approach. As one plan described it, “hiring bilingual employees makes all the difference in the world in effectively growing a diverse membership.”

D. Summary

The MMA was designed, in part, to foster competition among plans serving the Medicare population. It established new SNPs, one type of which was designed specifically to serve the dually eligible population. In response, there was some anticipation among the 11 demonstration plans that their markets would be affected as newly formed SNPs

“hiring bilingual employees makes all the difference in the world in effectively growing a diverse membership.”

competed to serve the dual-eligible beneficiaries. However, as of the first year of implementation and as experienced by the 11 demonstration plans, the markets serving their particular population had not yet radically changed. Demonstration sites in

Massachusetts and Wisconsin anticipated (and CMS numbers show) that in 2007 more SNPs would enter their markets and compete to serve the same population, and as such there may yet be competitive effects stemming from MMA not captured by this study. This was less likely in Minnesota because all the state's health plans were already offering SNPs through MSHO, and no new plans were coming into the state because of the non-profit requirement. The actual competition in Minnesota was anticipated from Medicare private fee-for-service products.

Plans experienced other effects related to MMA, however, including:

- the presence of PDPs and their outreach efforts to attract new members
- CMS errors related to enrollment
- member errors with respect to inadvertent enrollment in other plans
- the demands of complying with the new marketing guidelines.

The good news is that demonstration plan members were for the most part shielded from much of the transition turmoil. All plans were committed to serving their members while enrollment glitches were being sorted out, new co-payments were being phased in, and integrated marketing materials were being developed. The State Medicaid administrators recognized the extraordinary dedication and diligence of the health plans throughout the transition period. The enrollment data for the first six months show patterns of growth that are at least as good as prior years.

III. Prescription Drug Benefits/Part D

A. Relevant MMA Provisions

The Medicare Part D benefit shifted the bulk of drug coverage for the dual eligible population from Medicaid to Medicare, under which drug coverage was available only through several types of private plans. In addition to this major shift in coverage, the Medicare drug benefit itself has several mandates that were new to this population, and are relevant to understanding the impact of Part D on the dual demonstration plans and the population they cover.

- Mandatory enrollment of dual-eligible beneficiaries, either through their own decision or automatically.
- Mandatory copayments of \$1/\$3 or \$2/\$5 per prescription.
- MMA requires a special program of medication therapy management for all covered individuals with medication costs above \$4,000 and multiple prescriptions. This involved establishing a system to evaluate and manage drug use and spending for high-cost members, and could take place at the pharmacy, by phone, either managed in-house or contracted out.
- Formularies are required of Part D plans, with strict guidelines for coverage within certain drug classes. However, Part D drug plans may institute prior authorization for different drugs and through different structures than Medicaid programs had in the past used in their demonstration plans.

- Certain classes of drugs are not covered: most importantly, benzodiazepines and over-the-counter medications. Medicaid programs can fill in these classes, and receive federal matching for the costs, but it requires separate arrangements for payment to the plans, tracking, and prescribing.
- The appeals and exceptions processes for overriding the formulary have been revised in cases where there is a demonstrated need for a non-formulary or higher tier drug. Also, some previous provisions from Medicaid pharmacy coverage have been eliminated, such as automatic coverage of a medication while the appeal is pending.. However, guidelines for expedited review were established.
- Relatively simple, comprehensive, and free (for beneficiaries in demonstration plans) Medicaid pharmacy coverage was replaced by a more highly regulated and bifurcated system. Considerable reporting requirements were added for prescription drug management and special programs.

Relatively simple, comprehensive, and free (for beneficiaries) Medicaid pharmacy coverage was replaced by a more highly regulated and bifurcated system.

These new MMA policies and procedures required health plans and their partners (e.g., pharmacies and PBMs) to make many changes in the structure and terms of entitlement to prescription drugs for beneficiaries. Our questions regarding how the plans and beneficiaries fared under the MMA in the pharmacy area focused primarily on three themes:

- Access issues - including drug premiums and co-payments and utilization patterns.

- Pharmacy service operations - including formulary and network changes.
- Medication therapy management.

We report our findings below in terms of how the transition to MMA affected the plans themselves, followed by how these changes affected the plan members.

B. Impact of MMA on Plans

While the sum of Part D plus Medicaid prescription drug benefits for dual-eligible beneficiaries in the demonstration plans was quite similar prior to MMA as after, making the transition relatively seamless for beneficiaries took considerable work on the part of all of the demonstration plans. In considering the challenges and how they were addressed, it is important to remember that these plans were among a very few that covered all prescription drugs previously, and they may be unique among MA plans in their "planned" transitions. We address the following:

- Formulary changes
- Prescription drug management structures and processes
- Prescription drug utilization
- Medication therapy management
- Changing relationships with PBMs and pharmacies
- Staffing to meet reporting and new MMA-related administrative requirements

1. Formulary changes

The majority of health plans adopted new formularies with the implementation of MMA in compliance with specific CMS formulary directives and/or a national initiative for standardization. The plans reported that the MMA resulted in less flexibility for formulary management as there were more medication restrictions, as well as new notifications to make required changes in the formulary, to change prior authorization (PA) drugs, and/or to change the quantity limit. Plans stayed with the same PBMs they worked with prior to MMA.

The development of the formulary was reported to be a significant administrative burden for the health plans, since CMS made several changes to formulary requirements leading up to Part D implementation. For instance, managing the National Drug Codes (NDCs) for generic medications was reported to be tricky, since any one generic medication may have ten NDCs, and CMS may recognize only seven of them. Although the CMS directives were seen as complicating matters, the plans put them in the context of ever-evolving formularies normally within these health plans, regardless of MMA. One health plan described the formulary as a “living and breathing document.” As was the case prior to MMA, Pharmacy and Therapeutics (P and T) committees continued to meet to discuss and approve newly released medications, to consider inclusion of high-utilization medications and requests for additional medications from primary care providers, and to identify appropriate generic substitutions as patents expired on brand medications.

Plans took varied approaches to new formularies and related restrictions during the transition. One plan in Minnesota made the decision to suspend formulary changes for the first year of the MMA to avoid serious transitional issues related to the changes in prescription drug coverage. This decision affected only about four to five percent of the members, and the continued coverage of a brand-name, lipid-lowering medication accounted for most of the additional coverage provided. This MMA-required drug classification could be met with generics in 2006.

The Wisconsin plans reported that many members were initially maintained on non-formulary medications, despite the adoption of Part D formularies. The plans exercised great flexibility over the management of the prescription drug benefit but made efforts to change members to formulary agents when clinically indicated. The Partnership model (nurse practitioners and team) was reported to facilitate education and ongoing communication between the member and the PCP, facilitating medication substitutions. While health plans in Minnesota and Wisconsin reported more restricted formularies under MMA than previously, the health plans in Massachusetts believed that members had increased prescription drug access under the MMA. This perception was held due to the quite restrictive formulary policies employed by Mass Health (the State Medicaid program), so that adopting a Part D drug plan did not reflect much disruption.

2. Prescription drug management structures and processes

Prior authorization (PA) presented a considerable challenge for many health plans. Prior authorization is used for several purposes in this context. It is used to acquire approval to prescribe specific restricted drugs that are on the formulary, but because of clinical or economic reasons, should be used only in certain clinical conditions or after other drugs have been tried. It is also used to allow drugs that are on higher tiers to have lower cost sharing. Additionally, PA is used at the point of sale to determine whether a drug is included under the Part D formulary (covered through the drug benefit), or is covered through Medicare Part B (the medical benefit).

In most cases, prior authorization involved approval by telephone at the pharmacy. This is now conducted internally within some plans, with plan pharmacists responding to PA requests, and for others, it is conducted by the PBM. Most plans reported that the number of drugs subject to PA increased considerably with MMA implementation, requiring additional personnel or additional costs of PBM services.

Some plans created specific PA procedures for the correct assignment of Part B versus Part D prescription medications to ensure proper Medicare versus Medicaid cost allocation and to ensure appropriate member co-payments. Currently the distinction is based on whether the medication is administered by a health care provider or the beneficiary (self-administered) and whether it is given as part of a service in a physician's office or home. Part B generally covers medications that cannot be self-administered and

that are administered by or under the supervision of a physician in a physician's office. There are many other nuances in determining accurately Part B from Part D medications, such as immunosuppressive drugs given after a kidney transplant. If Medicare funded the transplant, the drugs are covered under Part B; if the transplant was not funded by Medicare, the drugs are covered under Part D. Additional confusion around Part B and Part D medications resulted from member transitions from the nursing home to community, since drugs that would be counted as Part B in the nursing home become Part D drugs when dispensed in the community.

While the proportion of drugs denied was reported not to have changed since MMA, the number of requests for PA increased tremendously. Plans believed this will be an ongoing impact of MMA rather than simply a transitional issue. Most plans did not believe that PA was limiting drug access, since decisions around pharmacy approvals were made in a timely manner. The increase in the volume of PA work greatly increased the administrative burden and related costs to the health plans. As with PA, the impact of this extra work related to Part D versus Part B drugs was not viewed as transitional by plans, but rather an on-going consequence of the MMA. At least one plan believed that the time spent on such interpretations could be eliminated by a CMS declaration listing specific drugs as Part B and others as Part D.

3. Prescription drug utilization

The plans believed it was too early to report any definitive changes in utilization, but a few plans reported apparent increases in generic dispensing. This was believed to be

either a result of tiered co-payments (higher cost sharing for brand drugs) or of the formulary restrictions, such as PA. While increased generic use may be a one-time change, if sustained, and if the cost of brand drugs maintains its current growth patterns, the cost of drugs may be mitigated. Additionally, post MMA, more members are using a 90-day supply, which some of the plans did not offer as a benefit previously. The impact of this on provider pharmacies may be adverse, as they collect one dispensing fee rather than three.

At least one health plan acknowledged an increase in its per-member-per-month pharmacy costs, and assumed that this was the result of the additional pharmacist who had to be hired to manage the PA process and other Part D requirements. From this plan's perspective, this change was not viewed negatively, since increased medication utilization can result in reduced hospitalizations. This plan remarked that this incentive provided a strong argument against stand-alone PDPs, which have financial incentives to reduce medication utilization and cost. Compared to PDPs and Medicare FFS providers, not only these dual integration plans, but all MA PDs would have this greater incentive to trade off increased pharmacy costs for reduced acute care costs. Additionally, they should be in a much better position to manage pharmacy and all other Medicare benefits than the PDP and Medicare FFS providers. At least MA PDs have everything all in the same tent. To the extent they rely on various downstream contractors to do the leg work, the efficiencies may be less, but the added pharmacist in this particular case might be something that other plans might find to be a cost saver in the long run.

4. Medication therapy management (MTM)

While all of the health plans had implemented MTM according to MMA guidelines, none could report any impact at this early stage. One plan remarked that the MTM program requirements added a new perspective on identification of complex cases via drug-specific cost, whereas prior to MMA member identification was based strictly on drug utilization or total medical costs. Many of the health plans implemented MTM in-house rather than via contracting, and they recognized the advantage of having the medical claims information in addition to the pharmacy data to design optimal interventions for members and providers. While most of the plans reported following CMS criteria for the identification of members eligible for MTM, a few plans extended the service to more members. One plan commented that MTM gives “another layer of opportunity to intervene and improve care.”

The plans had different approaches to MTM. One Minnesota plan contracted for the service. Once eligible members were identified following the specific CMS criteria for spending (\$4,000 annually in 2006), number of chronic diseases, etc., the plan pharmacist contacted the members and invited them to participate. (By CMS requirement MTM is a voluntary program.) If the member chose to participate, the plan was notified and the member had a “brown bag” education session with the pharmacist, in which all medications were reviewed. According to the protocol, if the pharmacist had recommendations for the member’s PCP, the pharmacist contacted the PCP, discussed recommendations, and determined if the PCP wished to make any changes. The MnDHO

plan utilized the service coordinators to facilitate MTM implementation. The service coordinator accompanied the member to the PCP and worked closely with the member and PCP to fulfill the goals of MTM.

In the Wisconsin plans, MTM was done for 100% of plan members prior to MMA and included oversight and management around medication utilization and adherence. Most of the Wisconsin plans' medication management activities extended well beyond MMA requirements, and according to plan and state informants, this was done not due to federal or state requirements, but rather to the complexity of the health status of members, the high number of medications they were taking, and the potential for adverse interactions. Therefore the real change post-MMA was documentation of the activities to satisfy CMS requirements. Processes that were already in place were formalized and documented. One of the plans provided medication data almost weekly to the pharmacist, who in turn discussed prescribing patterns and other issues with providers. Another plan delivered medications to most enrollees on a weekly basis. They reported that this gave them key information about compliance and effectiveness of medication regimens, and allowed them to make subtle, or not so subtle, adjustments to medications quickly while minimizing waste of medications previously dispensed. Over the last three years, the plan reported that their increase in drug expense was under 1% per year.

An innovative intervention reported by one of the Massachusetts plans consisted of running pharmacy claim reports for non-fills of maintenance prescriptions. Outreach to the member was initiated to determine the reason and attempt to resolve according to

identified need. If members expressed difficulty in accessing retail pharmacies, prescriptions were mailed. Education to clinical teams related to new developments in prescription medications was a key strategy as well. Two of the three Massachusetts plans' pharmacists met directly with PCPs and/or primary care teams to discuss high risk patients' prescriptions and to make recommendations for changes. The cost pattern of prescribing was also addressed to ensure that providers were prescribing in the most cost-efficient manner.

5. Changing relationships with PBMs and pharmacies

There are several MMA-related features that appeared to result in changes to the relationships between health plans, their drug managers, and suppliers. Plans worked with the same PBM prior to and after implementation of MMA, and the greatest change was the formulary. However, after the MMA the PBMs were required to perform new MMA-related services, such as reports and prior authorization, which incurred more costs to the health plans for PBM services. Regarding pharmacies, many of the health plans worked directly with small independent community pharmacies to provide drugs to their members, with special individualized service and a history with members. National PBMs contracted with larger chain pharmacies, which could afford to sign contracts at lower reimbursement rates. Most of the plans maintained or expanded their respective pharmacy networks, but most also expressed concern about the long-term impact of the reduction in business for small, neighborhood pharmacies. To the extent that MMA has resulted in some small community pharmacies being eliminated from plans' networks,

and to the extent that members may have shifted to other larger network pharmacies, this could result in subtle changes to services for beneficiaries (see below). Several plans reported that they were concerned that neighborhood pharmacies might be eliminated from networks, or had already facilitated members' change in pharmacies.

6. Staffing to meet reporting and other new MMA-related administrative requirements

Almost all of the plans hired additional staff to implement and manage Part D. Additional pharmacists and pharmacy technicians were hired by most plans to address the increase in PA volume and general formulary management. Even if PA was delegated by the health plan to the PBM, resources were needed to provide the required PBM oversight. In most cases, all the transition prescription fills had to be processed manually as overrides within respective pharmacy management systems. Plan informants said that the reporting requirements were enormous; and the time needed to remain updated via CMS teleconferencing, e-mails, etc. was said to be many hours a week. Several plans had to make system modifications to track the low income subsidy, true out-of-pocket costs (TrOOP), and other individual-level details to accurately manage the Part D benefit. The many requirements for Part D implementation substantially increased operational costs for the health plans, and the increases for small plans were much higher as a proportion of their previous administrative budgets. Although some of these are likely one-time costs (e.g., managing formulary-required drug substitutions), others are likely to be ongoing (e.g., tracking the LIS and TrOOP, managing increases in PA).

Examples of increased activities also included considerable time advising members on changes with MMA, the requirement for prescription co-payments, and preparing notices on members' status on Part D benefit spending. Regarding this last point, the plans had to send letters to beneficiaries explaining the Part D coverage gap (the "donut hole") and the coordination of benefits survey. Respondents said that these were extremely unlikely to be relevant to dual eligible beneficiaries and moreover, caused confusion and distress to members, particularly beneficiaries with limited English proficiency. Answering questions about these letters added additional cost and hassle to the plans.

Small plans hired pharmacists, pharmacy administrators, and/or new MIS staff to collect and analyze the data and make the reports. One Wisconsin plan that hired a second full-time pharmacist reported that 90% of his time was on administrative reporting, and only 10% was spent adding clinical value (why is this included in the section about bidding process?).

C. Impact of MMA on plan members

In this section, we highlight several areas in which beneficiaries were affected by MMA, both positively and negatively, and how plans responded. The impacts on members reported by plan informants mostly concerned access, co-payments, pharmacy networks, grievances, and impacts on integrated care.

1. Access to prescription drugs

The plan informants said that access issues for their members were not as widespread as they believed were reported by other MA-SNPs MA plans or PDPs. As described in the previous section, the demonstration plans allocated considerable preparation and resources to smoothing the transition to Medicare Part D. The smaller plans were particularly "hands-on" in their approaches. These efforts were reported to have been generally successful in insulating their members from some of the problems experienced by other populations in terms of continuity in access to prescription drugs. Additionally, enrolled beneficiaries had established relationships with these integrated health plans and consequently had a place to turn if problems arose at the retail pharmacies when trying to access prescription medications. Moreover, problems related to incorrect enrollment or co-payments could often be resolved at the point of service, with the pharmacies phoning the health plans on behalf of members.

2. Co-payments

All plans expressed concern that the MMA's required \$1/\$2 co-pays for generic drugs and \$3/\$5 co-pays for brands (although minimal) would affect access and compliance. Paying co-payments was new for dual-eligible beneficiaries who were in these plans prior to the MMA.

Despite the mandatory nature of the co-pays in MMA, there was variation across states in how co-pays worked. Minnesota was closest to the standard MMA procedure: All plans

charged the co-pays, and they were collected by pharmacies at the point of service. However, Minnesota law prevented the denial of filling a prescription due to inability of a consumer to pay, so the pharmacies were required to set up payment plans with individuals. At the time of the interviews six months after MMA implementation, none of the three plans had heard about significant problems with the payment or collection of the co-pays. One Minnesota plan had disbanded the co-payments for the first week in January by setting it equal to “zero” within their system. They subsequently changed it to the \$1 for generic and \$3 for brand (and \$2 and \$5 for those receiving Medicaid but over \$100 of poverty). They reported their greatest challenge was getting the pharmacists and members to understand the co-payments and annual cap limits.

In Wisconsin, two plans did not intervene in the collection of co-payments, and they reported that they did not receive very many complaints from members about co-payments, although they knew it could be a considerable burden for members using multiple drugs. Two other Wisconsin plans assumed some role in the collection of the member co-payments so that members were not denied prescription medication at the point of service (the retail pharmacies) for failure to pay co-payments. One plan delivered the drugs directly to members, so that they never interfaced with retail pharmacies (this was the case prior to MMA also). The plan then billed members directly for co-pays, and they reported a 60 percent collection rate. The other plan reported that co-payments were the greatest hardship stemming from MMA. To assure that no one would be turned away at the pharmacy, this plan made arrangements with local network pharmacies to provide medications to their members, and the plan would follow up with

member to collect the co-payment. This was agreed to by all except the large chain pharmacies (e.g., Wal-Mart and Walgreens). In the one plan that operated a WP program and a PACE program, members disenrolled intentionally from WP to enroll in PACE, which does not charge co-payments for prescriptions.

One Wisconsin plan reported negative impacts of MMA on institutionalized beneficiaries. CMS requires a one-month stay in the nursing home prior to waiving the co-payment. However, due to the lag-time in the CMS system for recognizing nursing home stays, beneficiaries were inappropriately charged for co-payments for several months. Additionally, as beneficiaries were transitioned from the nursing home back to the community, all medications dispensed by the long-term care pharmacy were destroyed rather than credited. The result was large increases in cost for new drug dispensing and claims processing during transitions into and out of nursing facilities.

The Commonwealth of Massachusetts decided to maintain zero co-pays for beneficiaries who joined SCOs by paying for the co-pay costs from state general revenues. The funds came to the SCOs in the state capitation payment. One of the plans reported that they paid the pharmacies through the PBM. In other words, the pharmacies and the PBMs kept track of what co-pays would be required, but they did not ask SCO members to pay. Rather, the PBM billed the plan, which paid the PBM, which paid the pharmacy.

3. Pharmacy networks

As noted earlier, the MMA brought with it an expansion of pharmacy networks for many of the demonstration plans, from those contracted to provide Medicaid prescription drug services, to networks developed by private Part D drug plans and pharmacy benefits managers. Some plans reported that a few community pharmacies that traditionally served their members had closed, or were no longer in their networks. Such small pharmacies often provided extra services that were important for some plan members, such as insulin pre-fills and home delivery. The impact that this had on beneficiaries in general may have been relatively minor, but for those beneficiaries who depended on local independent pharmacies to both counsel and provide individualized services, this was reported to be a huge loss. Plans had to either fill in additional counseling services, or help beneficiaries find alternative pharmacies.

4. Grievances

Only one of the eleven health plans reported the filing of any appeals for denied medications. In the single occurrence, it was a case involving the prescription for a non-formulary statin without an initial trial of the formulary medication.

5. Integrated care

At this time, plans do not report major obstacles to clinical care regarding continued integration of care in the pharmacy area. Apart from difficulties addressed earlier in this

report relating to different funding streams for medications versus other medical services, the plans were able to integrate services as before.

D. Summary and Conclusions on Prescription Drug Issues

Because our interviews occurred in the first half of the first year of MMA implementation, it is still very early to assess the full impact of the MMA's new Part D benefit on dual demonstration programs and their members. We can only speculate which transition issues will be ongoing and which will diminish as the Medicare drug plan matures. Nevertheless, lessons can be gleaned by documenting how these plans mobilized and adapted to the transition to Part D.

- First, because of the considerable planning period, and because of the hands-on history of the way in which all demonstration programs managed their members' drug benefit, the transition was relatively smooth for beneficiaries. An example was the fact that plans had relationships with community pharmacies and were able to rapidly step in to confirm a member's enrollment status if the CMS database did not recognize him or her. Also, if a local pharmacy was no longer part of a network, plans could guide members to pharmacies that could work for them. The required co-pays were being handled in a variety of ways, including ways that shielded members from full impacts, but even plans that charged full co-pays at the point of service were not yet reporting access problems.

- Second, because of the above planning, and the design of the low income subsidy, members of the demonstration programs were largely protected from significant gaps in Part D coverage.
- Third, Medicaid capitation payment and drug coverage largely worked. There were no complaints by plans in terms of the capitation amount provided for filling in uncovered drug classes.
- The impact of MMA drug benefit on plans appeared to differ by plan size. Transition was a bigger issue for small plans, as they often did not have adequate personnel (particularly pharmacists) to predict spending and manage the medication therapy management and prior authorization requirements of the new drug benefit. Paradoxically, members in these plans may have been more protected than members of larger plans, because of the hands-on approach in these plans.
- At the same time, the new regulations imposed a huge new administrative burden. In particular, many plans said they were now required to report on what they felt they were doing anyway as part of comprehensive care for frail populations. The added value of these requirements was sometimes, but not usually, seen.

Finally, as noted earlier, it is not clear which problematic issues were transition versus will be ongoing for the next several years. For instance, enrollment into drug plans may always involve a lag, because of newly eligible members' coming into the program, as state enrollment data are transferred to the CMS database. As such, plans may always have to have processes in place to alert pharmacies to their members' enrollment status.

Concerns were expressed that these administrative systems lapses occur just when beneficiaries may be experiencing significant episodes of illness that may have lead to the onset of Medicaid eligibility in the first place. As a result, due to complicated administrative exchanges, health plan opportunities to immediately address the spectrum of medical care and pharmacy treatment alternatives may be limited resulting in greater use and costs than might be possible if timely and efficient administrative procedures were in place.

IV. Summary and Conclusion

The foregoing analysis of the impact of the implementation of the MMA on these eleven integrated, comprehensive, demonstration SNPs found that all plans and state programs survived the MMA changes. The sites put their financial information into the new bidding tools and got paid rates that appeared adequate; they generally held onto their old members and added new ones; and they transitioned to Medicare payment and rules for the bulk of their prescription drug benefit. But accommodating the changes clearly was not easy, and questions remain about the future, particularly when their waivers expire in 2008.

In this concluding section we highlight three themes that cut across the finance, marketing, and pharmacy analyses. The themes include:

- "Cost-ineffectiveness" stemming from the large burdens and scant returns of the new MMA requirements - financial, administrative, and psychological - particularly for small SNPs.
- "Disintegration" stemming from the new forces the MMA introduced that seemed to pull apart the integrated Medicare and Medicaid finances, benefits, and services that these plans developed as demonstrations.
- Member/beneficiary impacts - the changed marketplaces, choices, and entitlements for beneficiaries, and how these SNPs tried to help beneficiaries through the changes.

Before turning to these themes, we want to re-emphasize that this report is based largely on informants from the eleven health plans under study and the state Medicaid staff overseeing these plans. Our study reflects the experiences that they chose to share - guided by our questions. We weighed what we heard in light of data and materials supplied to us by the plans and states, as well as CMS materials. We also talked to CMS staff to corroborate statements about how the MMA was being implemented in this early period. We also participated on phone calls with CMS, plans, and States prior to and immediately after MMA implementation. Another qualification is that we did not speak with or survey beneficiaries who were members of these health plans. Their experiences are reported entirely second-hand from health plan and state informants, and through the data showing their enrollment and disenrollment behavior.

A. Cost-Ineffectiveness

It is much, much more complicated and at least marginally more expensive to run an integrated Medicare/Medicaid managed care plan under the MMA than it was under Medicare + Choice. The burdens came out particularly in the form of required new administrative systems and activities, but also in new financial costs and in extra work time and stress for plan managers, staff, and even clinicians. Since the plans saw little if any benefit from these extra systems and requirements, the term "cost-ineffective" sums up the plans' views of these new burdens.

The burdens were most acute during 2005 for implementation in 2006. Everything was new for both CMS and health plans; there were many mid-course changes and corrections; and there were uncertainties about how it all would work. Just keeping up with all the written directives and conference calls was a major challenge, again particularly for small plans. The demonstration plans got the jobs done, but they pointed out that they had to pull financial, MIS, clinical, marketing, member relations, and even clinical staff from their regular duties and throw them into the effort of meeting MMA requirements. Long days and weekend work were reported to be routine, with spikes in activity as key deadlines approached.

Most plans said they had to increase staff and/or consultants contracts to meet the new MMA demands, including actuarial assistance. Almost all added to their pharmacy staff to adjudicate and track pharmacy claims and to manage new prior authorization

requirements, and some added administrative staff to answer after-hours member service phones. The costs of pharmacy benefit manager contracts certainly increased.

The amounts of information that the health plans had to collect, analyze, and report - not only to CMS, but also to beneficiaries - increased dramatically. Medicare health plans have long had to submit financial information to justify their benefits and premiums, but the new system required them to much more closely account for Medicare-type costs than ever before. Some of this new work will likely be one-time, while other parts will be recurring. Highlights of the new one-time work we heard about include:

- Learning the detailed rules for the two new bidding tools.
- Creating systems to "adjudicate" where the costs of individual bills and other costs belonged in the tools' spreadsheets.

Recurring work appears to include:

- Using the new tools to adjudicate claims.
- Working with PBMs to forecast pharmacy costs under new formularies.
- Working closely with actuaries who were required to certify the reasonableness and accuracy of the calculations.
- Getting the message out to members that they did not need to do anything to maintain their enrollment in their SNP, i.e., to tell them not to pay attention to all the other messages and messengers telling them that they needed to act.
- Reconciling the enrollment and disenrollment errors made by CMS, Part D plans, and members, and then straightening out the associated revenue and expenditure mistakes.

- Estimating, tracking, and reporting on drug rebates from manufacturers.
- Asking providers to submit bills splitting out by Medicare and Medicaid benefit coverage.

Site staff pointed out that many of the new requirements and systems seemed designed for MA plans serving private-pay populations, and that following them was irrelevant, extra work, or even counterproductive for the comprehensive dual-eligible SNP.

Highlights include:

- Sending members monthly notices of their TrOOP and "donut hole" status, when these reports were seen as irrelevant and confusing since the plans cover the dual eligible beneficiaries' full costs. However, if a beneficiary were to lose his/her Medicaid eligibility, the calculation of TrOOP becomes necessary.
- Adding 7-day/12-hour telephone information lines for members to call with benefit questions, when the plans already have systems for members to call their own care coordinators directly 24-7.
- Requiring an additional overlay of medication management for plans that have continual review through pharmacists on the care team.
- Complying with CMS requirements for the formulary, prior authorization, and quantity limits.
- Spending capitation funds not on services but to reduce the risk that there would be a premium that the members could not afford.

- Adjudicating pharmacy claims into Part B, Part D, Medicaid, and nursing home, and then working with pharmacies and PBMs to correctly report distinctions and charge or not charge members accordingly.
- Apportioning time and tasks of care coordination staff among Medicare administrative, Medicare clinical, and non-Medicare activities.
- Requiring plans to contract with pharmacies that would not accommodate a plan's arrangements for co-pays and home delivery.

B. Disintegration on Paper

The central purpose of the comprehensive demonstration health plans studied herein was to improve health care for special needs beneficiaries by integrating delivery of a broad range of health and long-term care services. Integrating Medicare and Medicaid is not easy, and the experiences of these plans, states, and CMS show that integration is multi-dimensional. It starts at the federal and state policy levels and runs down through arrangements for payment, reporting, regulations, and oversight. At the health plan level it includes changing relations among organizations and professionals, including how they are paid, communicate, report, and collaborate in care. At the beneficiary level, the goal is to provide simple, unified messages about benefits, enrollment, and access to services, even though members' benefits are being paid for by two programs that normally operate separately. The demonstration plans did not have perfect integration arrangements, but they had done a great deal to create seamless systems, particularly for beneficiaries.

In supporting these demonstration sites over the last decade, Medicare and Medicaid took something of a leap of faith to trust that their funds were being appropriately spent and that their benefits were being delivered in these integrated managed care systems.

Letting go of the need to track the spending of Medicare and Medicaid funds allowed these managed care programs to pay for administrative, care coordination, and services costs that are not typically covered under either program. While it is beyond the scope of our evaluation to assess whether or not this flexibility improved outcomes or saved money, those were certainly the objectives; and our earlier report showed that these plans did create coordinated care and benefit programs that seemed suited to the needs of beneficiaries with complex chronic illnesses and disabilities.

In a number of ways, the MMA essentially backed Medicare out of the pooling arrangements it has had with Medicaid in these plans, leading to what several site and state informants called "disintegration on paper." The most important area of disintegration was financial, where Medicare defined more explicitly what it would and would not cover in administration and benefits, and asked for more explicit tracking and reporting of the covered costs. There were also disintegrating policies in prescription drugs and marketing.

In the finance area, the key exclusion was home-based and community-based long-term care services (e.g., homemakers and personal care workers) and the costs of coordinating these services. On the surface Medicare's prohibition of using its funds to pay for HCBC care may not appear to be so important to the finances and operations of comprehensive

dual-eligible plans, since Medicaid covered these services and their management in its capitation. However, some site staff worried about three potential consequences of the Medicare stance. First, Medicaid also might begin requiring that its money be spent only on Medicaid-type services and management, and also asking for a more explicit accounting. Medicaid actuarial soundness provisions already require this, but tighter Medicare provisions in this regard may spur heightened Medicaid expectations. This would result not only in new cost tracking and reporting requirements, but also in a narrowing of the opportunity to use pooled funds to pay for benefits that were not explicitly covered by Medicaid, e.g., wheelchair ramps, air conditioners for beneficiaries with asthma. The site staff cited numerous instances where the flexibility from pooling allowed them to help beneficiaries in ways that neither Medicare nor Medicaid alone would allow.

Second, and perhaps more importantly, there may be future disputes between Medicare and Medicaid about who should pay for the substantial care coordination costs in some plans. Are the goals and impacts of these services and supports primarily to keep beneficiaries well (furthering Medicare goals) or independent (furthering Medicaid goals)? Are the services that care coordinators may be providing directly (a functional assessment and care plan by a nurse) or coordinating (a specially trained personal care attendant who can monitor and report on vital signs) more Medicaid or more Medicare? In the first two years of the MMA, the plans reported that CMS had not disputed their reporting of coordination and direct service costs for care coordinators as covered

Medicare administrative and/or service costs "above the line" on their bids, i.e., before the 25% is deducted from the rebate; but they feared future audits.

Third, sites pointed to a reduction in their incentives and abilities to spend money to change service delivery and administration in ways that would reduce utilization of Medicare services and generate savings. The reasons cited were three-fold: Only 75% of any savings would be returned in the rebate; there might not be enough allowable supplemental services left on which to spend the rebate; and the expenses to reduce Medicare service utilization might not be acknowledged as legitimate on the Medicare bid.

The MMA also required these plans to accommodate the disintegration of the financing and management of prescription drugs. This happened in several ways:

- The Part D benefit replaced a unitary financing system through the Medicaid capitation with a three-fold financing system composed of Medicare and required beneficiary co-payments, plus a Medicaid supplement.
- The plans needed to administer the Part D benefit in a manner consistent with fee-for-service tracking rules on the assumption that beneficiaries might switch to another coverage and eligibility status at any time, at which point their TrOOP, LIS, and co-pay status would need to be known.
- The plans had to administer distinctions among Part B and Part D coverage, and coverage during transitions into and out of nursing facilities; and they had to work

with (and pay) PBMs to help manage all this and more, and to work with pharmacies so that they charged (or didn't charge) the member the right copay.

- The plans had to mail beneficiaries monthly information about their Part D status and then explain when the members called for clarification that they didn't need to pay attention to what was mailed.

Thus, in contrast to the relatively smooth transition to the MMA in terms of continued coordination of financing and delivery of Medicare Parts A and B, and Medicaid long-term care benefits, the presence of Pt D tended to pull things apart rather than help foster integration.

Marketing was also in some way disintegrated, although not so severely. It was previously the case that both Medicare and Medicaid needed to approve marketing materials, and this had been done in coordination among plan, state, and CMS regional office staff. This approach continued after MMA, but CMS was said to have more requirements. Also, the official website for beneficiary information did not have the capability to list the Medicaid portion of the benefits covered in these plans.

C. Impacts on Beneficiaries

The MMA also changed the options, expenditures, and experiences of the beneficiaries in these plans. They certainly had new choices in the form of private prescription drug plans through which they could return to fee-for-service Medicare and Medicaid and receive most of the drugs formerly covered by Medicaid in their health plan. Now there

was a co-pay in fee-for-service Medicare, but there was a co-pay in Medicaid fee-for-service previously, too. The difference with MMA is that the prescription co-pay was now required in managed care as well.

The beneficiary's experience at the pharmacy was also at risk of change. If the plan, PBM, and pharmacy did not get their systems together to charge the members the correct co-pays for Medicare-covered prescriptions, and no co-pays for Medicaid-covered prescriptions, there could be confusion and possible rejections of prescriptions. Also, special relationships that their health plans had negotiated with some pharmacies (e.g., pre-fills for insulin syringes, home delivery) were not necessarily honored by all the pharmacies that the plans now had to include in their networks.

The Part D bidding process that was designed to potentially bring lower monthly premiums and better benefits to beneficiaries was also seen as having no benefits and high risks for the dual-eligible members of these plans. If the health plan bid above the unknown benchmark, members would need to pay a premium, which could also threaten the plan's existence. But bidding low provided no market advantage, since members would receive none of the lower premium dollars below the benchmark.

The new marketplace options also brought new information designed to help beneficiaries make informed decisions, as well as new marketplace rules for beneficiaries who did not make decisions. Because the options were many and the decisions important, beginning in each fall, beneficiaries were the recipients of waves of mailings

from PDPs, states, CMS, health plans, advocacy groups, and more. These were supplemented by public service announcements on radio and TV. Experts said that the best advice for making a cost-effective decision was for the beneficiary (or more likely their family member) to go to a web site and enter each prescription drug they were using and to compare the results in terms of coverage, prior authorization, co-pay levels, and monthly premiums - not an easy task for the low-income, special needs elders in these health plans. Moreover, the benefits of these dual-eligible plans were not accurately listed on the CMS website.

The task for the health plans became a matter of helping beneficiaries to not become confused or overwhelmed by the new options and information, and to not make a move that would remove them from the relatively simple, safe haven that these plans afforded. Fortunately the passive enrollment option eased that process. But the health plans reported that they received many, many phone calls from members - particularly members with limited English - asking what the mailings meant and what to do.

Despite the best efforts of plans to hold onto members, some mistakenly left their plan for a PDP, and still others were mistakenly disenrolled by CMS and assigned to a PDP. The numbers did not appear to be large, but the impact on the affected beneficiaries may have been significant. Apparently they usually learned of the changes when they went to get a prescription filled, their health plan card was rejected, and they were told they were in another plan. The plan staff told us that eventually mistakes were rectified with the help

of the plans, but the beneficiaries had to live through a period of limbo, and certainly further mailings and paperwork to sign, in order to return to where they started.

D. Conclusion

In summary, these plans, which had prior pharmacy coverage and MA enrollment, successfully transitioned to MAPD status in 2006, though the process continues to unfold into the 2008 MA contract year. The MMA was generally seen by dual integrated plans as being a cost-ineffective reform. It was seen to have resulted in a great deal of new work, significant new costs, distractions of managers and clinicians from their regular work, strains on integrated operations and tailoring services to meet special needs of beneficiaries, and confusion and new costs for the beneficiaries themselves. There was very little that was positive to which the plans could point. In the second round of bidding (in 2006 for 2007), the sites reported an easier time with assembling the data for their bids and completing the submissions, and meeting other reporting requirements; but new problems (e.g., enrollment and disenrollment mistakes) were appearing.

Given the basic structure of the MMA requirements for MA plans and the MA PD market, things are going to continue to be challenging for these comprehensive, dual-eligible SNPs. There are going to be more ongoing requirements in data collection and reporting than under M+C; there are going to be forces pulling toward disintegration of their integrated delivery systems; and beneficiaries are going to be faced with making choices in a marketplace that will remain confusing.

It is beyond the scope of this report to recommend policy changes to better accommodate integrated, comprehensive dual-eligible SNPs, either in terms of CMS regulations and guidance under MMA or possible legislative changes in the MMA statute. Current statute does not require dual-eligible SNPs to do any of the "special" things that these demonstration plans are doing, e.g., a companion capitation from Medicaid, a full range of acute and long-term care benefits, and coordination of acute and long-term care services. Nor does the statute include any special exemptions or alterations of reimbursement approaches to give health plans incentives to take on the additional risks and costs of serving a high-risk population. It remains to be seen how long these plans will be able to continue to offer integrated, comprehensive services under this policy structure, and whether the hundreds of new dual-eligible SNPs that are not operating comprehensive, integrated plans will move in this direction.

What kinds of approaches might policy makers consider if they want to more actively support the continuation of these integrated, comprehensive SNPs for dual eligible beneficiaries in the future? One issue - the continuation of a frailty adjustment to Medicare payment - has already been addressed in the February 16, 2007 CMS Advance Notice. In 2008, payments to plans will be weighted by 75% of the current FA-HCCs and 25% regular HCCs, going to 50-50 in 2009, and 25-75 in 2010, and 0-100 in 2011, when the plans will have no frailty adjustment. This will substantially reduce revenues over this period compared to currently, especially for demonstration health plans with higher adjustment factors. The Advance Notice reports on a new recalculation of the

frailty adjustment that has much lower frailty factors than the current FA-HCC formula, including for Medicaid beneficiaries. Thus, even if the demonstration plans were granted the new adjustors, it appears that frailty adjustment would not be as significant an added advantage as it is currently.

Another issue is how the plans participate in the MA bidding processes for Parts A/B and Part D. The need to buy down the Part D member premium cuts into Part A/B revenues formerly available to the plans. An alternative revenue model that respondents frequently cited is the system used in PACE, a program which differs from most the dual demonstration plans in that it serves Medicaid eligibles who are nursing home level of care and aged 55 and over. PACE programs do not bid on Medicare Parts A and B in the sense that their Medicare expenditures need to be accounted in the categories of the bid tool. Rather, the PACE plans are paid risk-adjusted capitation rates and allowed to apply all savings to services and administration. Further, the Part D bids for PACE programs are used solely to determine the Part D revenue; there is no monthly premium for PACE members and therefore no issue about generating sufficient savings on the A/B side to buy down the premium to the low-income subsidy. PACE also has no Part D co-payments.

One policy option would be for some PACE-like alterations in Medicare payment arrangements to be considered with the quid pro quo of offering dual-eligible beneficiaries a fully integrated system of benefits and care along the lines offered in these demonstration plans. CMS would need to articulate a set of requirements beyond the current SNP regulations (which concern only enrollment targeting and quality initiatives).

Required elements might include care coordination, coordinated chronic illness care, and integrated delivery of medical care and long-term care benefits. The latter would require health plans to work with their states and that the states be willing to participate in ways similar to the three models in the demonstration.

In summary, these prototypes for comprehensive dual-eligible SNPs provide tested and practical models for the MA program to appropriately serve beneficiaries who are among its most vulnerable and costly. The plans have survived the transition to the predominant Medicare managed care program, including offering the Part D benefit, but how they will survive, and how their comprehensive and integrated service models evolve in the context of the MA program in the next few years remains to be seen. Their special payment supports are being phased out, and there are no requirements in the current MA SNP model that they maintain their integrated, comprehensive service systems. Will these plans fend for themselves and make their own decisions about their futures - including the real possibilities that they will reduce benefits and care coordination staff, withdraw from Medicare or Medicaid contracts, and/or phase down as comprehensive dual eligible plans? Or, will the MA program evolve to incorporate successful features of these models in the dual-eligible SNP option? The latter course would allow not only for a continuation of these models of integrated Medicare and Medicaid services for the plans studied in this report in the three states of Massachusetts, Minnesota and Wisconsin, but also encourage other plans and states to emulate their approaches over time - without need for special demonstration authority.

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